

DOCTORAL THESIS

Stories of comedy and tragedy in therapy psychological therapists' experiences of humour in sessions with clients diagnosed with a terminal illness

Chauhan, Gauri

Award date:
2016

Awarding institution:
University of Roehampton

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

**STORIES OF COMEDY AND TRAGEDY IN THERAPY: PSYCHOLOGICAL
THERAPISTS' EXPERIENCES OF HUMOUR IN SESSIONS WITH
CLIENTS DIAGNOSED WITH A TERMINAL ILLNESS**

by

Gauri Chauhan BSc

A thesis submitted in partial fulfilment of the requirements
for the degree of

PsychD

Department of Psychology
Roehampton University

2015

Abstract

This research explores psychological therapists' experiences of humour in sessions with clients diagnosed with a terminal illness. In considering the extensive research uncovered involving humour and death, comparatively little was found in the field of terminal illness, humour and the psychological therapies, and none specifically on therapists' experiences of these phenomena. Bruner's (1991, 2004) narrative approach is used to examine six psychological therapists' experiences which elicited: participating therapists' personal experiences of humour compared to those experiences with clients; how preconceptions of working in terminal care shaped their experiences of humour once they were experienced therapists; the nature of working with terminally ill clients; the nature of humour as a hindrance and/or help; the differences between humour with clients in terminal settings compared to other settings; and finally, what therapists have learned through their experiences. Analysis of the findings is conducted by looking at both the content and structure of participants' narratives, paying close attention to character, plot, temporality, and situatedness. The nature of this research and the findings and their implications are discussed and critiqued, before further research is recommended and concluding remarks are made.

Table of Contents

Abstract.....	ii
Acknowledgements.....	v
Prologue: Gauri('s) Story	1
Chapter 1: Introduction	5
1.1 Preface.....	5
1.2 Plot.....	6
1.3 Definitions.....	8
Chapter 2: Setting the Scene	11
2.1 Introduction	11
2.2 Searching for literature.....	11
2.3 Criteria for relevance.....	12
Chapter 3: Literature Review.....	16
3.1 Introduction	16
3.2 Comedy and tragedy	16
3.3 Death and Dying.....	19
3.3.1 Terminal illness in psychological therapy	27
3.4 Humour.....	29
3.4.1 Humour in psychological therapy	38
3.5 Comedy, tragedy, humour and terminal illness in psychological therapy.....	51
3.6 Conclusion	54
Chapter 4: Methodology	59
4.1 Introduction	59
4.2 Quantitative research methods.....	61
4.3 Interpretative phenomenological analysis (IPA).....	64
4.4 Discourse Analysis	69
4.5 Heuristics	71
4.6 Narrative Analysis	72
4.6.1 Structural Narrative Analysis.....	75
4.6.2 Functional Narrative Analysis	78
4.7 Conclusion	84
Chapter 5: Method	87
5.1 Introduction	87
5.2 Data collection	87
5.2.1 Reliability, validity and generalisability	89
5.3 Participant recruitment and selection	91
5.3.1 Sample size.....	91
5.3.2 Criteria for selection	92
5.3.3 Recruitment	93
5.3.4 Participants selected.....	94
5.3.5 Ethical considerations	94
5.4 Interview procedure.....	95
5.5 Findings and analysis.....	96
Chapter 6: Results	99
6.1 Introduction	99
6.2 Findings.....	99
Characters.....	99
Scene 1: 'What brings you to my door?'	100

Scene 2: ‘A personal experience of humour’	101
Scene 3: ‘Capital S Serious’	102
Scene 4: Being guarded with the first client.....	103
Scene 5: ‘Humour in the early days’	104
Scene 6: ‘Working with the terminal’	104
Scene 7: ‘Humour’s actually risky’	106
Scene 8: ‘Humour helps treat the client like a person, not like a dying person’	107
Scene 9: ‘I don’t think it’s necessarily unique to this setting’	110
Scene 10: ‘I may well use humour as well’	112
Scene 11: ‘Out there, it’s not counselling’	113
Scene 12: ‘Humour in supervision, absolutely!’	116
Scene 13: ‘My learning is...’	116
Chapter 7: Analysis.....	119
7.1 Introduction	119
7.1.1 Characters	119
7.2 Plot.....	122
7.2.1 Reversal of fortune	123
7.2.2 Struggle between contending forces.....	124
7.2.3 The death.....	126
7.2.4 Revelation and recognition.....	127
7.3 Temporality	128
7.4 Situatedness.....	131
Chapter 8: Critique.....	134
8.1 Introduction	134
8.2 What was gained and what was lost?	134
8.3 Future research	141
Chapter 9: Conclusion.....	143
Postscript	146
Appendices	148
Appendix 1: Ethical Approval	148
Appendix 2: Invitation Letter	149
Appendix 3: Risk Assessment.....	151
Appendix 4: Consent Form.....	154
Appendix 5: Sample transcript.....	150
References.....	174

Acknowledgements

Thank you to Miss Youngman for first calling me ‘Gauri Story’, Mr Arnold who wondered if I had a brain, Dr Matt McDonald for first introducing me to existentialism and being a huge inspiration; and to all the teachers that in one way or another have led me to being here, but most importantly to Professor Del Loewenthal and Dr Rhiannon Thomas for their invaluable encouragement, inspiration and guidance in supervising this research.

Thank you Liz Nicholl and Karen Lemke for being my editors, to my colleagues and clients at the hospices for being so inspiring, and to Nimalmasi for playing that Rolling Stones song! Thank you also – massively – to the therapists that contributed to this research for your time and for your stories.

Particular thanks – for letting me sacrifice my time away from you and dealing so patiently with the myriad of emotions this brought out in me – to my family, particularly Mum, Pops, Amzz, Mama, Kuffee and Nani; and of course, to David, who not only let this be the third person in our relationship for way longer than it should have been, but also without whom this wouldn’t be what it is.

Prologue: Gauri('s) Story

When I first meet people, I often introduce myself as ‘Gauri, as in ‘gory story’’. This gets mixed responses from ‘Oh, I hope not!’ to ‘No, certainly not gory’, to inquisitiveness about the origins of my name. Whatever words are spoken, my introduction is always met with humour, a laugh or chuckle. In some kind of funny way, ‘Gauri('s) story’ is the signifier that pieces this thesis together.

But what is my story? And why put it down here? In many respects it would have been much easier to ignore this preliminary chapter or include it in the Introduction where it appeared in earlier drafts: a piece of writing that was, what I consider to be, academic clinical, succinct. However, it became increasingly apparent that this thesis would become a narrative study, and whilst the reasons for this are explained later (see Chapter 4), I decided that telling a story from start to finish in this way would provide some semblance of a coherent, rather than disjointed, structure to the whole of the narrative.

When I first came up with the phenomena I wanted to study: humour and death, I was certain it was purely because I was curious in how the two were manifest in my work environment at a hospice. I was quite sceptical of humour; surely it is just to make the therapist feel better, to take away the angst of standing on the precipice of an abyss of finitude that any counsellor working with any terminal client is all too aware of? However, it was during a few days of wrought exasperation, trawling through the thousands of words of interview transcripts, wondering how I could present my findings in a creative, playful way that honoured, as much as it could, the spirit of humour, that I first heard the Rolling Stones (2005) song ‘Laugh, I nearly died’. The chorus struck me as strangely apt, considering what I was doing, but it was

the wording of the verses that brought to full and immediate consciousness that this thesis is entirely about me: “I’ve been to Africa, looking for my soul/And I feel like an actor looking for a role...I’ve been down to India, but it froze my bones...I’ve been wandering, feeling all alone/I lost my direction and I lost my home.” The song is the story of my life! (At least so far.) Of Indian descent, I grew up in Kenya, taking for granted the sticky fruit, whistling thorn bushes and burning feet on hot tarmac. At 14, the luscious Kenyan soil was stolen away from beneath me, and I found myself stood instead with soggy feet on the drenched tarmac of Heathrow airport. I remember clearly at that time pushing the pain away, sticking my chin up, breathing England in and resolving to be a new Gauri; a more confident, less pathetic, highly positive Gauri. Although my propensity to turn negative situations into positive ones began a lot earlier (‘what can I learn from this?’ or ‘everything happens for a reason’ – probably having grown up in a quasi Hindu family driven by the wheels of karma and dharma), this was the moment that anaesthetising myself from my own emotions was galvanised. (There are earlier ‘tragedies’ in my life that may have contributed to this, but it is not my intention to exploit them by writing about them here. I am indeed the author of this thesis and this is my story, but it is also not *about* me. More, I want to acknowledge my own personal response to the tragic and/or the comic, and how potentially this could impact how I address the research question.)

Subsequently studying psychology, then working with learning and physically disabled people, and now as a counsellor in a hospice, my sense of ‘It could be worse!’ has only become stronger, much, I sometimes think, to my therapist’s chagrin – she often suggests to me that I do not acknowledge the pain in my life enough, I cover it up with pleasantry and good humour (or at least, that is what I hear!). I personally have no problem with this. After all, what’s wrong with always seeing ‘the

bright side of life' and ignoring what I consider to be the counterproductive emotions of sadness, loss and anger? Existentialists might tentatively suggest that I have succumbed to an 'inauthentic' existence – after all, is it not through the heat of the flame that a metal's impurities are burned off and gold is created?

In considering whether I am living an 'authentic' (or at least, an authentic *enough*) existence, what comes to mind is what my terminal clients sometimes say about quality versus quantity of life. Why bother going through weeks or months of invasive treatment to live a longer life, but one of pain, sickness and fatigue? Why not just ride out the last moments of a shortened life being able to get out of bed and 'feel ok'? I by no means am comparing the feelings of pain I disallow myself to the pain of my clients, but the question stands: do I live 'authentically', really acknowledging what angers me, depresses me, saying 'no' more, or live a happy life, blinkered from the gory? The Gauri. (I could potentially start introducing myself as 'Gauri – with an AU as in the periodic element of gold'.)

Covering up my pain with humour, a smile, a nod, appeasement, is something I am in a turbulent relationship with and one I am too scared to either break up with or get married to. Putting this down in words is, given the narrative method I have chosen, highly important not only in providing a coherent narrative, but also to ensure that in analysing my participants' findings I do not unconsciously project my own thoughts, assumptions, beliefs, wishes, conclusions, onto theirs. Not only will this maintain some kind of authenticity in my research, but also feels the 'ethical' thing to do. As Loewenthal (2011:151) supposes that Levinas might contend: "I am only attending to myself in order to be helpful to you; I need to have some sense of myself in order to put you first – to be in touch with my own concern with death and my own violence, in order to see it in your face." It is from this starting block that I now

present to you Gauri's story of psychological therapists' experiences of humour in sessions with clients diagnosed with a terminal illness.

Chapter 1: Introduction

“In literature we have the two basic genres, cultivated by the ancient Greeks and Romans, of tragedy and comedy, or the tragic and comic masks we wear on life’s stages and then internalize in the theaters of the mind, in the various scenarios created in the imagination and subsequently enacted with the therapist or analyst during therapy”

- Lothane, 2008a:181

1.1 Preface

It is the dichotomy of tragedy and comedy on which this study will focus, where comedy will be explored through examining therapists’ experiences of humour; and tragedy, through clients with terminal illness. As such, the overarching research question is: ‘How do psychological therapists experience humour in sessions with clients diagnosed with a terminal illness?’.

The idea for this study started with a consideration of humour in life in general, particularly those experiences where both sadness and joy are expressed through tears. These can also begin as one and end up as the other, such as when sorrowful wailing turns to uproarious laughter and vice versa. Freud (1927) acknowledged this association in his writings, where his use of the German word ‘humor’, according to Bergler (1956:39) depicts “a series of painful emotions transformed in a manner that produces pleasure”. Whilst this connection is not as explicit in English, common parlance reflects the juxtaposition between comedy and tragedy, humour and pain: ‘I didn’t know whether to laugh or cry’, ‘it was painfully funny’, ‘I could have died laughing’. These expressions have implications when considering the use of humour, and the role of ‘pain’ in such interactions: “When we consider the nature of humour it quickly becomes apparent that it produces laughter not so much by capitalizing on what we perceive to be pleasurable but from the

metamorphosis of pain into a psychically more manageable form” (Jacobson, 1997, in Lemma, 2000:43).

When the author started working in a hospice, the collocation of joy and sadness became more apparent. Humorous comments that were made about dying or death by patients, staff, families and friends felt like something greater than merely a flippant joke or quip; the laughter that accompanied such statements, whilst genuine, was also – at least for the author – slightly uneasy. From a general about the phenomenon, and considering the place of humour and death specifically in therapeutic sessions, to discovering a considerable dearth of previous research in the area, the idea to base a doctoral thesis on the experience of comedy and tragedy was born.

With the relative lack of previous research, it was felt that this study would be timely and suitable in illuminating the notion of humour in therapeutic sessions with terminally ill clients. In doing so, it is aimed at not only enhancing the work in such a context, but also addressing a broader question of how lived experience is researched, with implications for both research and therapeutic practice, particularly in palliative care settings.

1.2 Plot

The scene is set for this enquiry in Chapter 2, which explores the difficulties in researching humour and death, and how initial sources were found, with a discussion on the criteria that were set for determining the relevance of the literature to be presented. Given the lack of sufficient research exploring terminal illness, humour and psychological therapy, the Literature Review in Chapter 3 is a historical account of death and humour, which serves to contextualise the relationship between the two in therapy today. By harkening back to the concepts of comedy and tragedy in

Ancient Greek theatre, the case is put forward for the idea that comedy is borne from tragedy, and thus illustrates a potential human propensity to manage tragic situations through comedy. In attempting to explain how, literature on death is first explored. A history is provided of societal reactions to death and dying through Illich's (1976) six stages to gain a deeper understanding of the concept of death in today's society and its place in the psychological therapies. Some consideration is then given to several theories of humour that illustrate its role and function in society and for the individual. Of these, the three that are particularly examined are the superiority theory, the relief theory and the incongruence theory. Together, these identify how, pertinently for this study, humour can be seen as a response to the idea of death. Finally, existing literature interlacing humour, terminal illness and psychotherapy is presented. Together, these elements offer a legitimate structure for the enquiry to be launched.

Chapter 4 explores the values that route the journey to finding an appropriate method. These values are housed under an umbrella of relational, reflexive and contextual epistemology. The destination of this journey was to find a method which captured a rich enough description of therapists' experiences, acknowledged the contextual nature of humour and therapy, and maintained as much of the vitality and spontaneity of humour as possible. Interpretive Phenomenological Analysis (IPA), Discourse Analysis, Heuristics and Narrative Analysis are visited to assess their suitability, until finally the usefulness of Bruner's (1990) approach to narrative as a vehicle for presenting and analysing the findings is stressed.

Chapter 5 demonstrates the structure of the conducting the research, including data collection, a consideration of reliability, validity and generalisability, participant selection and interview and analysis procedures. Six psychological therapists

working in a variety of palliative care settings were interviewed for approximately an hour, the results of which can be seen in Chapter 6.

In wanting to maintain Bruner's (1991) call for plausibility and verisimilitude of the findings, and at the same time wanting to preserve the playful nature that humour inhabits, Van Maanen's (1988:19) thoughts were kept in mind: "little need was felt to do much more than gather and arrange the materials, for they would...speak for themselves". Thus, Chapter 6 uses the creative structure afforded by Bruner's narrative method to portray a story of psychological therapists' stories regarding their experiences of humour in sessions with clients diagnosed with terminal illnesses. By structuring the findings in this way, the author attempts to convey the subjective experience of being audience to what the participants spoke of.

Chapter 7 tells a story of the results through analysing them with the narrative concepts of character, plot, temporality and situatedness. Attention is paid not only to the content of the interviews, but also the structure. Hopefully, Chapters 6 and 7 together provide a rich account of participants' experiences of humour when working with terminally ill clients, as well as an exploration of the meaning that the therapists in this study have drawn from their experiences.

Chapter 8 provides a critique of the research as a whole by exploring the challenges and considering what was found and what was missed through approaching the research question in this way. Recommendations for future research are made, before the story ends in the concluding Chapter 9.

1.3 Definitions

In order to clarify the context in which this research has been conducted, the key terms will be defined here.

‘Psychological therapists’: those working with people using psychological, counselling or psychotherapeutic approaches to enhance their wellbeing, either short-term or long-term (BACP, 2014).

‘Experience’: rooted for the purposes of this enquiry in Husserlian philosophy (e.g. Husserl, 1931), this refers to the subjective and relative understanding one has of a particular phenomenon.

‘Humour’: The tendency of something to provoke amusement or a comic reaction. For the purposes of this research, the Association for Applied and Therapeutic Humour’s official definition of therapeutic humour will be used:

“Therapeutic humour is any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life’s situation. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual.”

(www.aath.org)

‘Sessions’: The time in which the psychological therapist and client meet for purposes of psychological support.

‘Clients’: With an acknowledgement that clients are sometimes referred to as ‘patients’ in literature and palliative care settings, ‘clients’ refers to those that are seen by psychological therapists for support. For the purposes of this study, clients will be those diagnosed with a terminal illness.

‘Diagnosis’: The implicit medical determination of a disease or condition, of which both therapist and client – for the purposes of this investigation – is aware.

‘Terminal illness’: A term that describes a disease or condition that has progressed to an extent where it can no longer be cured. Patients diagnosed with a terminal illness are generally expected to die within a relatively short period of time, though definitions vary from within six to twelve months (e.g. National Institute for Clinical Excellence, 2004). The term is commonly used for progressive diseases such as cancer, heart disease, and a number of degenerative neurological illnesses (McNamara, 2006). Other terms that have been used include ‘chronic illness’, and more recently, ‘life-limiting illness’ (e.g. Department of Health, 2008).

The chapters that follow are parts of a jigsaw, each coming together to offer a story that unfolds to describe the author’s journey from a starting place of relative ignorance regarding humour and death, and with voices of doubt, misgiving and hesitation when in these situations. The form and description of the journey takes a storytelling frame, consistent with the values of narrative, which requires the teller to set the scene for the telling. Each of the chapters, whilst standing alone, paves the path for addressing the question: How do psychological therapists experience humour in sessions with clients diagnosed with a terminal illness?

Chapter 2: Setting the Scene

“Life does not cease to be funny when people die any more than it ceases to be serious when people laugh.”

- Shaw (1906:130)

2.1 Introduction

This chapter sets the scene for answering the question of how psychological therapists experience humour in sessions with clients diagnosed with a terminal illness by considering the complexities involved in searching for existing literature. This is followed by a discussion determining criteria for the relevance, inclusion and presentation of previous research in the Literature Review.

2.2 Searching for literature

Humour and death are vast topics, with their branches reaching into the realms of cinema, music, psychology, science, television, and many more. At the time of writing, a Google search of ‘death and humour’ elicited 27,400,000 results. These included articles on ‘gallows humour’, websites listing humorous death quotes, funny epitaphs and obituaries, and even the odd news story with the headline, ‘Cannibal killer beaten to death over sick sense of humour, says prison murderer’ (Papenfuss, 2015). With such a broad range of material, it was almost a relief to see that ‘death humour psychotherapy’ had only 420,000 results on Google. Interestingly, only 25,200 of these results are on Google Scholar. What becomes apparent is an incredibly vast area of potential exploration, with relatively less published content.

Given this expanse of research on humour and death generally, there was a requirement to focus the initial literature search for published items through not only Google Scholar, but also journal databases such as PSYCArticles, PSYCInfo, PSYCHBooks and PEP-Web. The key terms searched for included ‘psychological therapy humour terminal illness’, followed by ‘humour psychological therapy’, and

‘psychological therapy terminally ill’. To ensure the maximum amount of relevant literature was sourced, variations of the words were used, such as ‘psychotherapy’, ‘counselling’, ‘comedy’, ‘life limiting illness’, and so on, as well as Americanised spellings of the words. The key terms yielded numerous results but it was found that by the sixth page of most databases, results seemed to be less relevant.

Journals were accessed through Shibboleth and Athens and then read, with attention being paid to both the content and bibliographies, as these made reference to other potentially relevant journal articles and books. Books that had been identified as potentially useful were sourced through the university library or purchased, either as hard or electronic copies. Once it was decided that reading new articles and conducting further searches generated no new sources of information, it was decided that enough relevant existing literature had been discovered.

2.3 Criteria for relevance

In considering the literature to include, it was acknowledged that the plethora of literature allowed for a number of different avenues which could be followed, and as a result, a number of different doctoral theses that could be produced. For instance, one potential area of exploration could be looking at defining therapeutic humour; another, exploring the purpose of therapy for clients with terminal illness. Not knowing at this early stage which direction this thesis would take, and with the necessity to provide a focus to a broad, and potentially unfocused, topic in the mature fields of death and humour that have attracted a lot of attention, it was important to maintain strong boundaries in establishing the criteria for relevance. By so doing, the chance of being overwhelmed by the literature and therefore producing an overly saturated and ‘thin’ account of what already exists was avoided; therefore, a deep and rigorous exploration of the pertinent research that was specifically relevant to the

research question was attempted. To only include what was immediately relevant and not tangentially related to the main focus of the investigation, it was necessary to get a clear idea of what was being asked and the platforms from which the study was being launched, namely: comedy and tragedy, death and dying, humour, and the relation to these three to the psychological therapies. Therefore, the criteria for determining the relevance of articles were that they should focus upon working with clients diagnosed with a terminal illness or refer to occurrences of humour in the therapeutic setting, or preferably both, and that they should explore the implications each of these have for therapeutic practice.

Whilst space did not permit a thorough enough exploration of how the relationship between death and humour changes throughout time and culture, and in order to keep it relevant to the contextual and culturally dependent complexities of both humour and death (e.g. Fox, 1990), it was only Western notions of death, humour and the psychological therapies that were decided to be the focus of the literature review.

Whittling down the results revealed a relative dearth of literature that explores the triadic relationship between terminal illness, humour and the psychological therapies. The majority of literature regarding these phenomena was disparate, anecdotal or quantitative, and largely written from a psychoanalytic perspective. There was no significant literature written specifically about psychological therapists' experiences of humour whilst working with terminally ill clients, but humour was mentioned in some articles and books about counselling and terminal illness.

The history of both terminal illness and humour were found by the author to contribute to current societal and individual attitudes to the topics and an attempt to systematically analyse the literature into themes iteratively and recursively as

suggested by Braun and Clarke (2006) was felt to jar with the content. In accordance with Hart (1998), a chronological presentation was deemed to work best for this literature review in allowing for a narrative to be produced that sufficiently encapsulates such a rich history and provides a framework for making distinctions between perspectives. What follows is an amalgamation of the two approaches by locating literature along a chronological line where possible and organising it loosely in themes, which enabled the researcher to identify work that is perceivably at the edge of the paradigm and can reveal something about the nature of originality. This resolved the issue of what felt like a heavily structured and somewhat rigid thematic analysis, and allowed for a critical position to be developed towards traditional assumptions.

Furthermore, the majority of research has been carried out from a psychoanalytic perspective and hence cannot be ignored, despite the author's desire to present the literature from an existential viewpoint. Existentialism, in giving import to subjectivity over objectivity (e.g. Sartre, 1956) lends itself well to the phenomena of exploration in this thesis as the subjective and diverse experiences of both humour and death have important implications on adequately researching such phenomena, particularly in relation to psychological therapy. Thus it is tentatively suggested that this thesis may inhabit an 'existential-analytic' (Loewenthal, 2016) space in which the exploration of these phenomena is arrived at from "one evolution of R. D. Laing's approach to existentialism, including the influence of psychoanalysis, though this is preceded by giving a primacy to the existential relationship". Hence, it is the individual relationship between death, humour and psychological therapy that is felt to be key to exploring the experience of these phenomena.

In considering the implications of this on adequately researching such phenomena, it is worth keeping in mind that attitudes towards death and humour both inhabit and are products of cultural and individual circumstances, borne of a distinct relationship, which have a distinct history, at a distinct place. Particularly, the nature of humour is intangible and not just found in the content of utterances, but also in the tone of one's voice or in a particular gesture or expression. In relating this very contextual moment either verbally or textually, there is not only a risk of losing the essence of the phenomena, but the possibility of misunderstanding the humour and the reception it elicits is significantly increased (Lemma, 2000). Other authors have also pointed out the difficulty in retaining the funniness the moment humour is examined: "Just as sex research tends to shrivel romance, so pontifications about humour are death to amusement" (Dixon, 1980:287). This is an unavoidable limitation to be acknowledged, and kept in mind. That being said, the contradiction of writing a thesis on humour, which is so painfully unfunny, has in itself a certain kind of ironic comedy.

Chapter 3: Literature Review

“A little perspective, like a little humor, goes a long way.”

- Klein (2014)

3.1 Introduction

What is the relationship, if any, between humour, terminal illness and the psychological therapies? To offer an answer, it is necessary to examine the existing research that explores each three areas, which will further serve to contextualise this current study. This literature review therefore begins with a general investigation of the history of tragedy and comedy, where the case is put forward for the idea that comedy is borne from tragedy, illustrating a potential human propensity to manage tragic situations through comedy. To explore this in greater depth, literature on death and dying is first presented, followed by a more specific examination of terminal illness, and then the relationship between terminal illness and psychological therapy. An evaluation of humour and then its relationship with psychological therapy follows, before literature interlacing terminal illness, humour and psychological therapies is considered.

3.2 Comedy and tragedy

There has been much debate over the centuries over what exactly tragedy is (see for example, Kerr, 1967; Roche, 1998; Poole, 2005; Taplin & Billings, 2010). From around 500BC with the development of Ancient Greek theatre through to the Renaissance and Judaeo-Christian and Shakespearean tragedies, this debate has often focused on its form, or shape and plot (e.g. Cartwright, 2013). It is worthy to refer here to Aristotle’s ‘Poetics’ (trans. 2003), and the ‘Unities’ of time, place and action that arose out of it.

‘Poetics’ portrayed tragedies to typically depict a great character, serious, dignified and admirable, who experienced a reversal of fortune due to “hamartia”, which Taplin and Billings (2010) point out is often mistranslated as ‘flaw’, but more correctly depicts ‘mistake’. The hero suffered, there was a struggle, a combat between two contending forces, which ended in a lamentable death – lamented because he sacrificed himself in a necessary action that would in the end serve the common good of man. Through the process, the hero was rewarded and achieved revelation or recognition, in Aristotelian terms, “a change from ignorance to knowledge” (Aristotle, trans. 2003:33).

Kerr (1967) points out that there are tragedies, however, that do not conform to this structure, nor the unities of time, place and action, but are nevertheless powerful and moving and appear to have the same ‘tragic effect’. In debating the definition or nature of tragedy therefore, it may be necessary to look at this tragic effect. The question regarding what it is about tragedies that compels audiences to continually return to watch them may be answered by how people experience tragedies, and it is here that the audience rather than the play itself becomes the central defining feature. Aristotle (trans. 2003) originally depicted tragedies as eliciting fear or pity in the audience, but also as a means of catharsis. Though he failed to define what he meant by catharsis, the original Greek word ‘κάθαρση’ (*kátharsi*) means ‘purification’ or ‘cleansing’ (Thomas, 2009), and the experience of watching tragedies can thus be seen as a purging of certain pent up emotions.

Taplin and Billings (2010) however, argue that the idea of releasing something from the body in this way does not seem to encapsulate the experience entirely, and suggested that perhaps there is something that can be extracted from tragedies and “put into our bodies”. They likened tragedies to an inoculation or vaccination in

which the virus strengthens our bodies, and proposed that watching tragedies may strengthen viewers for life outside of theatre, not in attempt to ward off suffering, but to increase understanding and insight. According to Taplin and Billings (2010), this idea corresponds well with the original ancient Greek terminology for playwrights as ‘teaching’ tragedies rather than ‘writing’ them.

Ancient Greek tragedies followed a particular structure of three plays in which a first ‘*agon*’ (implying agony) gave birth to a second, and the second to a third. The third “acted as an ultimate discharge of pain and responsibility and ended in reconciliation” (Kerr, 1967:22). These trilogies were followed by a fourth play, a ‘*satyr*’, which made use of the original material of the tragic plays but almost made light of it and was considered comical.

Lacan (in Zupančič, 2003) compared the structures of tragedy and comedy to the relationship between actions of desire. For Lacan, the essence of tragedy is the triumph of death, the willingness of the tragic hero to choose death as an expression of choice and dignity in a confrontation with the real. In contrast, he viewed comedy as an unconscious structure that expresses the individual’s capacity to choose life in an encounter with the real, within the limits of existence. Tragedy then, can be seen as an exploration of man’s freedom or limitations, which perhaps has important implications in working with people with terminal illnesses: on one hand, their bodies are bound – like Prometheus was, but chained, he was still free to challenge Zeus (Aeschylus, trans. 1961). It is a possibility that using comedy, or humour, is one way in which people can challenge their limitations. Roustang (1987:711), for instance, associates the comic with tolerating uncertainty, or as “freedom’s possibility to escape from itself.” Tolerating limitations, particularly the ultimate impingement of death,

could be said to generate considerable anxiety, which can be worked through sublimation. Humour, it is argued, provides a vehicle for this (Lemma, 2000).

Accordingly, Barwick (2012:165) discussing a ‘postlapsarian’ world, argues that humour has a role in managing life's multiple ‘falls’:

“Free, but no longer provided for, mortality epitomises our desire to do more than we are capable of and to be more than we are. In ‘the gap’ that characterises this world, aspirations and creative acts are inevitably shadowed by frustrations, losses and myriad ‘falls’, and it is humour that is often used, developmentally and/or defensively, to lighten the shadow and to manage the psychic residue of these falls.”

There is hence a strong indication of the human predisposition to use comedy to mitigate against the effects of tragedy, and theorists have deduced from this the possibility that, “comedy at its most penetrating derives from what we normally regard as tragic” (Kerr, 1967:17), akin to the sun and the shadow – the two are almost one and the second unthinkable without the first. The catharsis of tragedy could then be said to give way to a kind of consolation from comedy when it depicts the absurd and grotesque aspects of life in humorous ways.

The idea that comedy emerges from tragedy and has an apparent underlying purpose that seems serious, despite its intention to make people laugh, is interesting and will be explored in what follows. Tragedy will be explored through reviewing historic and current literature on death, dying and more particularly being unavoidably confronted by these in terminal illness; comedy, through humour; and lastly, the significance and interrelationship of both these phenomena in psychological therapy.

3.3 Death and Dying

With the idea that comedy potentially emerges from tragedy, societal attitudes towards death and dying through history are the springboards from which terminal

illness and its situatedness in the psychological therapies today is explored. Illich's (1976) six-phase model illustrating the evolution of societal attitudes toward death and the role it has had in health and healing through history seems pertinent here in providing a context to current thoughts about terminal illness, and the extent to which this influences psychological therapists working with clients diagnosed with such illnesses. It must be acknowledged that this is particularly relevant to Western society, and may not necessarily be applicable to other cultures or communities.

Illich (1976) claimed that the dominant image of death was shaped by institutional structures, myths and social constructions prevalent at specific junctures of time. According to Illich, the first stage of the evolution of ideas regarding death began in the Middle Ages, and followed a time when death was considered to be God's deliberate and personal intervention. Death began to be accepted as an autonomous part of human life and society was more accepting of it as a natural, rather than mystical, event.

The second stage, starting in the twelfth century, demonstrated a move from conceiving death as a transition to the next life, to death being the end of one's current life. The Church was still powerful at the time, and whilst doctors could aid healing, attempts to prolong life were considered blasphemous (Illich, 1976). The Black Death, which peaked in the fourteenth century, brought around folk practices and superstitions that were believed to contribute to a 'good' death.

The Industrial Revolution, which according to Foucault (1976) created employment and wealth, and hence a bourgeois culture that desired good health, formulates Illich's (1976) third stage. Disease started to be considered a political and economic problem, and along with the desire for a 'useful' society, death became an 'untimely' event for the healthy and young (Foucault, 1976). The medical market

gained distinction, old charitable institutions were dismantled by the state, and the classes that could afford it began to pay to keep death away (Foucault, 1976; Illich, 1976).

During stage four of Illich's (1976) model, doctors, in being viewed as having the ability to control the outcome of diseases, were also believed to have power over death which afforded them new status (Shyrock, 1947). Supporting this idea, Reck (1977) describes other cultures, which are shown to value death, and compared them to Western tradition, where it is life that appears to hold import. Reck (1977) claims that this is largely shaped by Darwinian philosophy from the nineteenth century, where survival is the goal for all organisms.

The fifth stage, which occurred towards the middle of the twentieth century, follows on from this, and demonstrates health as being a commodity. The sixth stage, according to Illich (1976) has been the time in which:

“protected against dying and defeated by the victory of medicalization over society, the patient is no longer able to set the scene for his own death; nor can the professionals who have taken control of life and death agree amongst themselves what actually constitutes death”

(O'Gorman, 1998:1130).

Technological advances in medicine as well as a movement towards smaller, more nuclear families resulted in an increase of dying in institutions, a dramatic difference from the Middle ages and Renaissance when

“a man insisted upon participating in his own death because he saw it an exceptional moment – a moment which gave his individuality its definite form. He was only the master of his life to the extent that he was the master of his death. His death belonged to him and to him alone”

(Illich, 1976:5).

Added to this is the possible feeling that doctors and nurses have failed if the patient dies (Pietroni, 1991).

Illich's (1976) model has received a lot of support from authors writing in the late seventies and early eighties (e.g. Taylor, 1977; Reck, 1977; Weir, 1980, Thompson, 1984) who highlight how the medicalisation of society resulted in an increase of people dying in hospitals or extended-care facilities such as hospices and nursing homes rather than at home, and how this contributed to a societal denial of death. They called for a more 'realistic' view of death to acknowledge the problems that confront everyone as death approaches including the inevitability of death, the finality of death, the untimeliness of death, the necessity of death-related decisions, and the complexity of death-related decisions (Weir, 1980).

According to Taylor (1977:182), "institutionalized death rationalizes the process and, in doing so, turns dying people into objects". Bodies are taken over by professionals, who prescribe their own rituals and often fail to satisfy the spiritual needs of the individual and their family (May, 1973; Illich, 1976): "When we get sick today, we end up in the bailiwick of the physician and nurse; when we are about to die, there is the clergyman; and when we actually die, there is the funeral director. Dying and death have become the province of the professional" (Feifel, 1977:7). A consequence of institutionalising death is the isolation of the patient, what Sweeting and Gilhooley (1992) refer to as a 'social death', which precedes the biological death. According to Taylor (1977), grieving often began after the death because the primary focus for relatives was to care for their loved one. When death is institutionalised however, grieving tends to begin from the outset because death is acknowledged as an inevitable outcome. This has been referred to as 'anticipatory grief' (see Reynolds & Botha, 2006), and can affect both dying individuals and those around them. Moreover, people have the option, and often do choose, to prolong their lives no matter what suffering and pain due to treatment their extra time might bring them.

Technological advances have also impacted society's attitudes towards death, with twenty-four hour news coverage of natural and man-made disasters, video games, television shows and movies. As Wong and Tomer (2011:100) state:

“Our passive acceptance of the endless coverage of carnage and atrocity betrays a love-hate relationship with death: We are simultaneously repelled by its terror and seduced by its mysteries...The ubiquity of images of death may be seen as an opportunity. Lifting of the taboo may have paved the way for death to emerge as a popular subject for both psychological research and public education.”

Current research supports the idea that there has been a return to society adopting more holistic views towards death and dying (e.g. Barry & Yuill, 2012). Hospices, for instance, are increasingly enhancing strategies to enable the individual to die at home with the right support, which includes a plethora of professionals from doctors and nurses to chaplains, complementary therapists, counsellors, psychologists, social workers, and so on, with aims to meet the psychosocial needs of the patient and not just the biological (e.g. Social Care Institute for Excellence, 2013). By so doing, they attempt to prolong the quality of life and enhance the experience of death. This change of attitude towards dying could be said to result from research conducted by Kübler-Ross (1970), who indicated that dying could be a peaceful and transformative experience, and the work of Dame Cicely Saunders (1978) who initiated the hospice movement.

Literature (e.g. Aabom, et al., 2005) has identified that diagnosing someone as terminal is problematic; physicians either do not define their patients as being terminal or tend to provide optimistic prognostic estimates, resulting in inappropriate and untimely referral to specialist palliative care services or unintended acute hospitalisation. For this reason, this study intends to explore those therapists working with clients that have already received a terminal diagnosis from their doctors, and are

subject to palliative care. Palliative care is defined by the World Health Organisation (2014) as “an approach that improves the quality of life for patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering...and treatment of pain and other problems, physical, psychosocial and spiritual”.

Kisner (1994) indicates the impact society has on an individual diagnosed with terminal illness. For instance, she refers to the metaphorical use of the word cancer, which according to her, “is used to represent insidiously destructive conditions in our culture...to denote some widespread evil process”. Phrases such as ‘it spread like a cancer’ equate certain phenomena with contagion, evil, punishment and death, which potentially serve to enhance its negativity. The World Health Organisation (Stewart & Wild, 2014), for instance, issued a warning referring to cancer as a ‘tidal wave that will threaten the world’ and refer to cancer as a ‘global burden’. Kisner (1994:136) warns, “such moral overtones are dangerous because they can instil fear and guilt in one who may develop ‘cancer’”. Orbach, 1999:109) also states that:

“in most countries in the Western world there is now a growing realisation that modern medicine, increasing our span of living, has increased our span of dying too: and we all know of those who feel that because of cardiac resuscitators, antibiotics and so on, they are now being obliged to live longer beyond their natural term.”

One can be reminded here of Foucault’s (1961) interpretation of the allegory, ‘Ship of Fools’. Foucault points out that originally, lepers were excluded from society but that once leprosy physically disappeared, the space it occupied in society was filled by the concept of madness, and it was madmen that were isolated and expelled from communities. He likened madness to death: in the late middle ages when Foucault was writing, though death was not marginalised, it was seen as something opposed to life. Madness, akin to death, was also frightening and threatened life and

reason, and became a means to express and locate concerns about the darker side of life and fear of obliteration. This raises the question as to what extent, if at all, terminal illnesses such as AIDS and cancer have now become the symbol for the projection of society's fears and negativity; or, as Kisner (1994:136) states, “‘Cancer’ (the person with cancer) becomes the scapegoat on which (whom) those problems most unacceptable to society are projected”.

Society's view of cancer could be related to the varying ways in which people face and accept the finitude of their existence. There is a wealth of literature from existentialist writers (e.g. Heidegger, 1927; Sartre, 1943; Yalom, 1980) who refer to individuals' tendencies, through certain behaviours and preoccupations, to avoid and repress the awareness of life's finitude and the resultant isolation and angst. Echoing Foucault, Becker (1973) refers to this as a “collective madness” through which dieting, exercise and other attempts at ‘self-improvement’ – writing a doctorate, perhaps – are not only a guise for control, but also obscure awareness of impending death. Testament to this is recent advertising campaigns ‘personifying’ cancer as something that is the enemy that can be beaten. On one hand, phrases such as “Now it is cancer's turn to be afraid” (Cancer Research, 2012), could be said to instil hope in individuals that cancer can be thwarted in the same way that terrible human beings may eventually be overcome and defeated through unwavering perseverance, more so than something abstract, devoid of reason and feeling, which mercilessly, unscrupulously and relentlessly causes suffering and death. Depicting cancer as a being transforms the abstract into something tangible, empowering people in the face of illness. On the other hand, doing so is also a means by which one can potentially blinker themselves from the inevitability of their finitude.

Reck (1977) argues that technological developments that prolong life and avoid death have resulted in longevity being the main value. He also comments on the “unfortunate paradox” that has resulted in those instances where, in attempt to ward off death, the weeks or months that treatments provide are spent in considerable suffering or pain. Kisner (1994) suggests that those with terminal diagnoses, in being confronted with their mortality, are unable to perpetuate suppressing that which allows them membership in the ‘collectively mad’ society, living with a constant reminder of the existential realities of uncertainty, meaninglessness, isolation and finitude. In reference to AIDS, but able to be extended to other terminal illnesses, Guibert (in Orbach, 1999:126) states, it is “an illness in stages, a very long flight of steps that led assuredly to death, but whose every step represented a unique apprenticeship. It was a disease that gave death time to live and its victims time to die, time to discover time, and in the end to discover life”.

Whilst much of the research has focused on negative responses to mortality, Reed (1986) suggests that there are also positive responses. She argues that awareness of personal death enables the integration of its inevitability and an exhibition of more positive death perspectives than those who are not faced with imminent death: “confrontation with death is a confrontation with time. It is generally thought that there is an intimate relationship between the meaning of death and the meaning of time. The desire to know if and when the ‘end’ is near attests to this” (Reed, 1986:468).

According to Reck (1977), the denial of death and the rejection of one’s absolute finitude, detrimentally influences the opportunity for personal growth. In comparison, “until the last moment of consciousness the dying may not only communicate significantly with others, but also find the inner meaning of their lives.

Personal value of this sort is achieved when an individual knows that death is near and accepts the fact” (Reck, 1977:319). Whilst this may not be the case for everyone, Reck goes on to highlight the pertinence of talking therapy in such occasions as a means to enhance psychological growth once “the biological course towards death cannot be averted by medical means” (Reck, 1977:319). He quotes Weisman (1972), who suggests that this would result in a ‘purposeful death’, by which he means “a death that someone might choose for himself – had he a choice...one must realise that death is not an ironic choice without an option, but a way of living as long as possible” (in Reck, 1977:320).

3.3.1 Terminal illness in psychological therapy

A number of authors have highlighted the ‘uniqueness’ of counselling provision for clients diagnosed with life-limiting illnesses. Jackson (1977) for instance, refers to time factors and the intensity of emotional involvement being different to therapy with those who are not confronting death. Jackson also comments on the potential for repressed hostilities that arise when a healthy person (the therapist) moves into context with a dying client, and the grief that might arise:

“Dying people are facing a bereavement that has to do with the essence of their own being. They are not only losing life, they are losing everything that life made significant. They are losing family, they are losing occupation, and possessions; they are losing the sense of identity that makes it possible for them to establish selfhood”

(Jackson, 1977:28).

Jackson claims that this may create feelings of aggression or hostility, which may be directed at the therapist but is therapeutically valid. He contends that “the more rational the approach to death on the part of the professional person the more perspective he can have on the needs of those who are emotionally involved” (1977:28).

Kisner (1994:133) also describes the nature of terminal illness as presenting the mental health professional with “a special challenge”:

“treatment needs are unique because they share the following: 1) A diagnosis to which society reacts with hopeless negativity; 2) An approach or combination of approaches to treatment (surgery, chemotherapy and/or radiation) that often results in severe alterations in body image beyond the fact of having the illness; and 3) A confrontation with issues of mortality, uncertainty, aloneness and meaninglessness, i.e. existential concerns, because of treatment-free periods when one waits to see if the disease recurs”.

Kisner (1994) goes on to describe how a patient with a terminal illness may view a mental health referral as either an indication of their insanity or a threat of abandonment by his doctor for not being ‘a good patient’ or what LeShan (1990) refers to as a ‘façade of goodness’. Kisner (1994) claims that this is compounded by the patient’s anxiety and fear of losing further control following their diagnosis. Rawnsley (1982) divides this fear into three categories pertaining to fears about relationships with significant others, fears about managing the illness, and fears about the loss of self.

Lederberg and Holland (2011) have summarised key differences in the ‘application’ of therapy for those with terminal illnesses. They indicate a requirement for the loosening of boundaries, for instance in location (e.g. home or hospital visits, telephone or email), length of the session (due to the client’s possible fatigue), and frequency of sessions (medical setbacks have the potential to ‘reset the cycle’). They also encourage the therapist to have a flexible approach in exploring feelings surrounding diagnosis, treatment and the end of treatment; an understanding of the disease, as the client’s subjective understanding can be different to reality; and an understanding of denial. The authors specifically refer to two levels of co-existent knowledge that may arise for some clients: realistic and wishful, which can lead to

feelings of ambivalence of ambiguity. They also highlight how changes to the body can influence thoughts regarding their physical self versus their psychological self, before and during the illness.

Working with a client diagnosed with a terminal illness can also confront the therapist with issues of mortality. Lederberg and Holland (2011) highlight the importance of psychotherapists' awareness of countertransference reactions, comfort with their own subjective experience of death, and self-care. The role of the therapist with terminally ill patients is then, according to Orbach (1999:72), to experience and acknowledge "a helplessness that both of them share: therapists may find themselves put in the position of 'ultimate rescuers', to relieve another person's suffering, and must resist any temptation to 'rescue' either of them by a reassurance that would be a denial of the pain".

3.4 Humour

Before the literature regarding humour is explored, it is important to draw a distinction between humour, which refers to something comic and/or amusing, and laughter, which is not necessarily a response to something funny (such as in instances of anxiety (e.g. Lemma, 2000) or tickling). Neither humour nor laughter are necessary for the existence of the other, though it could be argued that laughter may provide the 'catharsis' that Aristotle (trans. 2003) spoke of, much in the same ways that tears are sometimes experienced as a release of energy or tension. Further, with humour being highly relative to time, location, culture, maturity, education, intelligence and context (Morreall, 2009), some consideration of the history of humour research to contextualise current thinking is necessary.

There appears to be a rejection of laughter, amusement and humour in history. For instance, Epictetus (125, in Morreall, 2009:4) advises, "Let not your laughter be

loud, frequent or unrestrained". St. Benedict's rules also enjoin a restraint against laughter, encouraging monks to "prefer moderation in speech and speak no foolish chatter, nothing just to provoke laughter", and the Irish monastery of Columban warned against joking with the following punishments: "He who smiles in service...six strokes; if he breaks out in the noise of laughter, a special fast unless it has happened pardonably" (in Morreall, 2009:5). Friedman (2000) points out that instances of humour in the bible, too, are not depicted as happy and joyous, but as sarcastic and derisive: "He who sits in heaven will laugh, the Lord will mock them" (Psalms, 2:4); "My Lord laughs at [the wicked] for He sees that his day is coming" (Psalms, 37:13); "But as for You, God, You laugh at them; You mock all nations" (Psalms, 59:9).

Whilst humour is more acceptable today, the word itself did not refer to 'funniness' until the seventeenth century, but rather to 'humoural medicine', which purported that the balance of bodily fluids in the human body, 'humours', determined a person's physical and mental qualities (Morreall, 2009). This led to a sense of 'mood' and 'temporary state of mind' that finally resulted in 'humour' being used to denote 'amusing quality, funniness' in the 1680s (Fowler, 1926). Humour is defined today in the Oxford English Dictionary as "the quality of being amusing or comic; a state of mind".

There has been an increasing interest in interdisciplinary humour research (e.g. McGuire, 1999; Buckman, 1994; Ortiz, 2000), and Franzini (2001) reports on the scope of benefits of humour spanning multiple domains such as the medical (e.g. increasing the quality of life and alleviating pain in terminally ill patients; Kisner, 1994), physiological (e.g. increasing endorphins levels and improving natural killer cell activity, Levinthal, 1988; Bennett, 2003), social (e.g. expanding one's network of

friends and contributing to a more pleasant social stimulus; Fry & Salameh, 1987; Ruch, 1998) and psychological (e.g. providing coping mechanisms for stress and enhancing personality traits; Fry & Salameh, 1987; Buckman, 1994; Kuiper & Martin, 1998).

The complexity of humour as a concept is evident in the plethora of theories arguing what humour is and what functions it serves. Although many classical theories of humour and laughter may be found, contemporary academic literature (e.g. Morreall, 2009) focuses on three main theories: ‘incongruity theory’, ‘relief theory’, and ‘superiority theory’, each of which will be explored below and used as frameworks for relevant research. Amongst current humour researchers however, there is no consensus about which of these is most viable, though there is a general acceptance that many instances of humour can be explained by more than one theory. As Raskin (1985:40) notes, the three theories “characterize the phenomenon of humor from very different angles and do not all contradict each other - rather they seem to supplement each other quite nicely”.

With regards to the ‘incongruity theory’, Hutcheson (1725, in Telfer, 1995) described laughter as a response to the perception of incongruity between a concept and the real object, an idea that has been supported by Beattie (1779), Schopenhauer (1819), Kierkegaard (1841) and Kant (1892). Humour through incongruity, it is argued, entails the assimilation of unexpected and sudden shifts in perspective, or absurdities, in instances where our normal expectations are violated by a given event. Kierkegaard (1841), for instance, purported that the ‘comical’ is intrinsic to life and emerges wherever there is a contradiction. The more thoroughly one exists, he claims, the more comedy can be discovered. The comic perspective, according to Kierkegaard, sees a way out of tragedy, whereas a tragic perspective despairs of a

way out. Nietzsche (1883) supports this idea in his depiction of Zarathustra using laughter to liberate himself against the absurdity of life's suffering: "Nietzsche's higher men...will be joyful, dancing heroes who transcend the tragic stance; the lesson they offer is that facing a world without epistemological or ethical foundations, our highest and most authentic response is not pointless rebellion, but laughter" (Morreall, 1990:132). In considering the absurdities of existence, Kant (1792) states:

"In everything that is to excite a lively convulsive laugh there must be something absurd (in which the understanding, therefore, can find no satisfaction). Laughter is an affection arising from the sudden transformation of a strained expectation into nothing. This transformation, which is certainly not enjoyable to the understanding, yet indirectly gives it very active enjoyment for the moment. Therefore its cause must consist in the influence of the representation upon the body, and the reflex of this upon the mind"

(in Morreall, 2009:11).

Kant's statement also implicates a paradox in our desire to constructively manage conflicts and contradictions. In other words, "we appear to seek out that which disturbs us at some level but which, through humour is transformed in such a way that anxiety is lessened and can be experienced as pleasure" (Lemma, 2000:40).

The 'relief theory' can be attributed to Shaftesbury (1711), who referred to the relief afforded by humour: "The natural free spirits of ingenious men, if imprisoned or controlled, will find out other ways of motion to relieve themselves in their constraint; and whether it be in burlesque, mimicry or buffoonery, they will be glad at any rate to vent themselves, and be revenged upon their constrainers" (Morreall, 2009:16). However, Freud's (1905) theory is referenced in, and appears to be the basis for, many publications on the topic. He initially formulated his conception of humour on the idea that the pleasure it produces allow the psyche to triumph over the impingements of repression or painful reality; the resultant laughter is an orgasmic release of affect. Humour and the resulting laughter, according to Freud, is an

unconscious process through which superfluous psychic energy is released. By this, he meant the energy that represses feelings (such as sex or hostility) rather than the energy of the repressed feelings themselves, arising “from an economy in the expenditure of affect” (1905:284).

The relief afforded by humour can also be seen as a mechanism through which tension and emotional pressure are reduced (Stephenson, 1993; Erdman, 1994), and paradoxically to enable clients to access feelings of sadness and loss: “At certain times, laughter is more accessible than crying, and at times it is possible to feel how close hard laughter is to sobbing” (Pierce, 1985:70). Morreall’s (1983) theory that laughter, like crying, relieves built up energy can be likened to the catharsis of the Greek chorus in ancient plays. Thus, the potential satisfaction experienced in tragedies may not be from the grotesque or horrific content, but possibly from admiration for the hero and possibly even relief from boredom, but also maybe relief that it is not us who are the hero (MacHovec, 1991).

Laughter has also been allied to the orgasm, as Lothane (2008a:186) states, “listening to a joke, whether sexual or hostile, is accompanied in the listener by a mounting tension, in itself pleasurable, leading to the climax of laughter upon the delivery of the punch line”. Mann (1991) purports that the release of repressed material also enables spontaneity:

“In the genesis of a joke, a preconscious thought is given over for a moment to unconscious revision, enabling a partial, transient and involuntary release of some impulses or feelings ordinarily, or at least currently, repressed. The outcome is at once grasped by conscious perception. We experience a sudden release of intellectual tension, and then all at once the joke is there, ‘ready clothed in words’”

(Christie, 1994:481).

Considering the spontaneous nature in which humour can arise also implies a certain playful creativeness (Koestler, 1964; Winnicott, 1971; Pasquali, 1986). As

Barwick (2012:166) notes, humour is “both the promoter and the product of a flexibility of mind, of a capacity for spontaneity and playfulness, that is essential to creative living”.

Many authors have used this creative nature of humour to highlight a sense of liberation or emotional freedom that arises from its use. Welsford (1935) in considering the history of fools and clowns, concluded that the fool had a function as the ‘creator of freedom’ by voicing truths that others refrained from contemplating: “The Fool is the primeval condition that churns and rumbles within us all as we seek to know and he represents the ground that assures us that we do not” (Janik, 1998:20). As Alvarez (1992:67) points out: “Pleasure should not be thought of as inferior to pain in its capacity to disturb, alert and enliven”. Baker (1993) provides further support for this notion arguing that humour potentiates vitality and optimism.

With regards to the ‘superiority theory’, Hobbes (1651:36) can be seen to extend Plato’s original ideas that laughter was an expression of one’s superiority: “Sudden glory is the passion which maketh those grimaces called laughter”. This idea can also be seen in Freud (1905:122), where as well as being a release of psychic energy, humour is both borne of, and an outcome of, superiority:

“By making our enemy small, inferior, despicable or comic, we achieve in a roundabout way the enjoyment of overcoming him...A joke will allow us to exploit something ridiculous in our enemy which we could not, on account of obstacles in the way, bring forward openly or consciously”.

Ferenczi (1911) summarized Freud’s theory by stating that the humourist “rises above his own troubles...while the ordinary person abandons himself in sad emotion”. Freud (1927:63) revisited his theory and reconsidered the nature of the superego, depicting it as having a more loving and comforting function, exemplified

by humour triumphing over narcissism, “a victorious assertion to the ego’s invulnerability”.

Poland (1990:199) comments on the developmental aspect of humour, which he likened to psychosexual development and the emergence of the maturity of object relationships, through a greater ability to appreciate the other, finitude and reality’s limits. Laughter is hence a means by which frustrations and disappointments are maturely acknowledged “with a humour in which bitterness is tamed but not denied” (Christie, 1994:485). Humour hence enables a capacity to deny painful reality, but also to deflate feelings of omnipotence (Bader, 1993) by providing a sense of power over uncomfortable or difficult situations (Ruxton, 1988) and mastering emotions (Goldin & Bordin, 1999; Lothane, 2008b).

A number of psychoanalytic authors concur with these ideas, arguing that a ‘mature’ sense of humour requires either ego strength, allowing one to rise above narcissism (Christie, 1994), or “sufficient skills of mastery for at least a partial taming of drive urgency...The quality is of acknowledgement and even acceptance of pain and loss without resignation to depressive hopelessness and hatred” (Poland, 1990:4). Lemma (2000:47) argues that a mature humour “conveys a willingness to share and be open about our vulnerabilities”. She contends that through humour we suspend emotional involvement and quotes Bergson who said that humour demands a “momentary anaesthesia of the heart” (Lemma, 2000:80). Pasquali (1986) suggests that under the pretext of ‘it’s only a joke’, an element of conflict within one’s nature is acknowledged. By so doing, inherent anxieties are transformed by humour to be more bearable, thus enabling the ability to confront and explain them. This can also be implicated as a means to manage self-worth and develop self-understanding (Britton, 2003; Barwick, 2012).

The superiority one gains through humour can be extended to superiority over life events. For instance, Sartre (1938) and Bergson (1900) both link humour to subject and object, suggesting that laughter is a means by which the other is turned into an object, while in fact the humourist themselves are objects pretending to be subjects. Thereby when one laughs at themselves they are being traitors to themselves: “In Sartre’s view, humor has its purpose to save the spirit of seriousness. Ridicule denounces false seriousness in the name of true seriousness. Laughter is a panic reaction, he says, like shock, flight or terror, which blows the whistle on subhumans pretending to be human” (Morreall, 2009:132). This idea is supported by Stephenson (1993:175) who portrays humour as a means to gain control over fears by making light of situations in which people may otherwise be afraid that things are going ‘out of control’ or will be overwhelming. He claims that in its most extreme form, this sort of humour can take on a macabre tone, and states, “the word death has power in its meaning and its connotations. For many, it is a hard word even to say. However ‘how’ we say a word is often more important than the word itself. To say it within a humorous situation, or story, or joke, disarms it and renders it less ‘powerful’”.

Sartre’s view can be seen to lend support to Freud’s argument that humour enables an individual’s rejection of being “distressed by the provocations of reality” (1927:162). Phillips (1993:90) interpreted this as humour “rescuing our pleasure from the obstacles”, obstacles that are self-imposed, but also consist of the inhibited impulses created by the inescapable demands of society. This feels to the author to be of particular pertinence when considering the nature of terminal illness, not least because of the large body of work in academia and popular culture that cites ‘gallows humour’. Freud’s (1927:161) joke not only reflects the brevity of life, but as Newirth

(2006a:560) claims, it “emphasizes the necessity to take pleasure in one’s circumstances to transcend the universal experiences of limitation, persecution, powerlessness, meaninglessness, and insignificance”. Lothane (2008a) points out a threefold purpose to jokes such as these: they allow an assertion of liberation from reality, provide a comic relief from the anxiety, and proclaim defiance against society.

Barwick (2012:171) claims that this and other variants of the joke (e.g. in Bergmann, 1999) provide an irreverent omnipotence, that also suggests an element of choice, and bestow “some sense of self-respected dignity where otherwise there is only powerlessness, shame and humiliation”. In this way, humour propounds a temporary but illusory triumph over death. Similarly, Berlyne (1960) referring to those with terminal illnesses, notes that humour can contain a “healthy use of denial”, suggesting the ability to overlook fears of an uncertain future and Kisner (1994:149) states, “instead, this person with cancer would put his energies into doing what can be done to improve the situation. The ultimate goal of this use of denial is to preserve one’s intimate relationships, something which the inclusive form of humour can enhance”.

Freud’s (1927) theory can also be seen to imply that humour as a means to transcend personal difficulties and become courageous. Thorson (1985:206) added to this that humour about death is an “offence mechanism”, a means by which one laughs in its face and gains control over the uncontrollable:

“By making our own death unimportant, we make all death less important. This is a defence mechanism with teeth, and elevates humor to the level of two other areas of human endeavour, medicine and theology, that seek to have control over death...While it cannot deny the reality of death...it can deny the importance of the reality of death. Death personified with pie in its face has lost its power. Tomorrow we die, but at least for now we can eat, drink and be merry”.

Thorson (1985) claimed that rather than being a denial of death, this was an acceptance of the reality of death's role in life. He added one additional element of death humour not found in Freud's work, that of mocking others who have died or will die. He links this with the original idea of Greek wit in which those with unusual frailties were laughed at for not being like others, and where the dead were laughed at in celebration of those that were living, providing superiority in comparison.

According to Barwick (2012:171):

“an aspect of the empowerment the disempowered feel in utilising humour is often also derived from the diminishment, in their own minds at least, of the power of the oppressor. Although this is not entirely an unconscious maneuver, the manner in which primitive feelings – powerlessness, humiliation, shame – can be pushed, through humour, from oppressed onto and even into oppressor, suggests that projective processes are at work”.

“Humour in such a situation insists that one is above the dangers that the external world can inflict, that even in extremities, one can use the situation to extract some pleasure” (Freud, 1927:162). Gallows humour hence allows the assertion and rebellion against “one's helpless condition” (Lemma, 2000:85).

3.4.1 Humour in psychological therapy

The three humour theories, incongruity, relief and superiority, complement each other and illustrate how humour encourages one to access deeper feelings in addition to finding relief from pressure and mastery over the uncontrollable. It is now necessary, however, to consider what place these have in the psychological therapies.

Literature (e.g. Bevis, 2012) reveals significant debate in determining a definitive definition of ‘therapeutic humour’, from Freud's (1905:228) conception of humour as “a means of obtaining pleasure in spite of the distressing affects that interfere with it” to the Association for Applied and Therapeutic Humour's official depiction of it as:

“any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life’s situation...[which] may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual”

(www.aath.org).

Current research (e.g. Franzini, 2001) describes therapeutic humour as including a formal structured joke or riddle, a pointing out of absurdities, an unintended pun or spoonerism, behavioural or verbal parapraxes, examples of illogical reasoning, exaggerations to the extreme, statements of therapist self-deprecation, repeating an amusing punch line, illustrations of universal human frailties, or comical observations of current social and environmental events. Typically, the result is shared by the therapist and the client, which could range anywhere from quiet empathic amusement to overt loud laughter, and overall, an emotional experience, mostly positive but also potentially negative.

The relatively conspicuous sparseness of literature about humour in the field of psychological therapy could possibly be attributed to the complicated nature of researching the phenomenon (Baker, 1993; Lindenman, 1995; Lemma, 2000; Franzini, 2001; Lothane, 2008a). Of what does exist, the majority of papers are clinical anecdotes and subjective case examples (e.g. Haigh, 1986; Richman, 1996; Bader, 1993; Ortiz, 2000), and are written from a variety of psychoanalytic perspectives (e.g. Mosak, 1987; Streaan, 1994; Franzini, 2001), somewhat ironically due to the reputation of psychoanalysts to be serious, grave and sombre (Lemma, 2000).

Literature largely focuses on the implementation of humour and whether or not it should be used in psychotherapy, indicating potential benefits or pitfalls of its use (Franzini, 2001). The quantitative studies that exist (e.g. Killinger, 1977; Golub

1979; Golan et al., 1988) depend on simulated or recorded sessions, which not only lack external validity (Ortiz, 2000), but the contrived nature of the humour or therapeutic relationship portrayed may result in the humour being taken out of context and therefore seem insensitive or inappropriate (Lemma, 2000). As such, the literature review provided here will not rely heavily on quantitative data in its report of the use of humour in psychotherapy. Readers interested in such a discussion are encouraged to read Shaughnessy and Wadsworth (1992) and Saper (1987).

The reported dearth of humour research could also be attributed to a lack of interest in the area, or, as some theorists (e.g. Baker, 1993; Lemma, 2000) have suggested, an anxiety about the fantasised reception of such research. Though it is acknowledged that humour is used in sessions, not many therapists seem to disclose their use of it openly in formal arenas. Pierce (1985:67) comments on his reluctance to share humorous moments with colleagues or students, as it felt “risky”: “Many humorous interchanges are particularly lively and personal, probably among the most personal moments shared in therapy. So while I don’t think most of us use humour in our therapy sessions, I think we use more than we let other people know”. Accordingly, Baker (1993) suggests that as therapists have a propensity to hear, respond to, and contain clients’ pain and suffering, they may feel more at ease with working with suffering than with pleasant and enjoyable content. He suggested that as a result, therapists might be dubious about the role of humour in sessions. This has been supported by Lemma (2000), who, in a pilot study researching psychoanalyst’s attitudes towards humour and laughter in psychotherapy, found that therapists were reluctant to openly discuss their use of humour due to possible disapprobation from colleagues due to feelings that humour was not useful or legitimate in psychoanalysis. She states,

“perhaps the use of humour in psychotherapy is generally thought to be best avoided due to a confusion between doing serious work and being serious. Serious work can be achieved without having to measure its seriousness through how many tears the patient has shed or how much anger or envy he has been able to express”

(Lemma, 2000:5).

The paucity of literature may thus both imply and compound the idea that “this is an area where analysts prefer privacy, as in other areas where they might attract criticism from their colleagues” (Baker, 1993:952).

Of the literature that does exist, a plethora of writers have agreed with the notion that a client’s use of humour seems to: be an indication of a person’s being self-actualised (Maslow, 1954); help clients laugh at themselves, clarifying self-defeating behaviours in a non-threatening way and puncturing grandiosity (MacHovec, 1991); aid personality integration (Mann, 1991); potentially diagnose the degree of progress they achieve in resolving many former and current life-stage developmental issues (Kisner, 1994); lead to improvements in the self-understanding and behaviour of clients (Franzini, 2001); and provide a sense of authority of the client’s psychopathology and affective and cognitive development (Newirth, 2006b). Kisner (1994:149) reporting on group therapy noted that “those group members whose use of humor tend to include the leaders and others in a way that conveys a willingness to share the moment, have made peace with themselves which has enabled them to go on with their lives.”

There is also a body of subsequent support for the usefulness of humour in enabling clients in therapy to: identify and express feelings (Pierce, 1985; Mann, 1991), stimulating ‘unconscious metacommunication’ between therapist and patient (Bader, 1993); providing a ‘safe’ outlet in which ‘truths’ can be stated and emotions can be confronted (Stephenson, 1993); establishing a comfortable atmosphere by adding balance to life and breaking down barriers (Erdman, 1994); expressing

ambivalence, making intense, forceful and emotive interpretations more acceptable (Goldin & Bordin, 1999); breaking through resistance and helping the therapist to deal with difficult topics (Ortiz, 2000); reaching the patient emotionally (Fabian, 2002; Lothane, 2008b); and as a means of communicating painful insights within an affectively safe context (Newirth, 2006a).

In relation to psychoanalysis, Klein (1961:243-4) suggested that the pain and distress aroused by the anxieties and conflicts explored are only tolerated because of the “longing for integration and insight”, including those anxieties in which the therapist is seen as a persecutory figure. She noted,

“I have repeatedly observed that some patients – children and adults – also experience not only satisfaction but also amusement about some part of their mind, usually found to be bad or dishonest, being found out by the analyst and by themselves. In my experience these are people who have a sense of humour, and it occurs to me that one root of the sense of humour is the capacity to experience satisfaction about finding out in oneself something that has been repressed”.

Christie (1994:485) assumed from this that the playfulness of humour allowed a momentary communication that enabled a contact with libidinal or destructive impulses and allowed a brief transformation of their hidden forces: “A creative thrust is released that can facilitate further ego-integration and broaden perspective and understanding”.

Theorists have also connected feelings of surprise in instances of humour to the feeling of surprise in therapy. Reik (1913; 1936) for instance, likened humour to psychoanalytic insight, which he described as “the conformation of repressed expectation” (1933:325). He claimed that two responses followed. Firstly, the surprise of repressed material being brought to conscious awareness, and secondly, the release of affect (relief in analysis and laughter in wit): “The discovery is an exhilarating experience for the patient, like Archimedes’ joyous shout ‘Eureka’ (I have found it)”

(Lothane, 2008b:233). O'Donovan (1985:62) commented that "this is where the Aha and HaHa feel alike, and make a difference that is alike...The insight may be unpleasant, but it still shares some physical dimensions with the act of laughter; there is a climactic moment similar to catching on to a punchline". Further, Baker (1993) likened those clients that had fixed inhibitions and hence unable to experience surprise, to those who tend not to respond spontaneously to jokes and are equally unsurprised.

Through the surprising and confrontational nature of humour, clients may be able to better recognise the absurdity, hilarity and enjoyability of life and hence discover new ways of looking at things (MacHovec, 1991; Goldin & Bordin, 1999). May (1953:53-54) described humour as being "the healthy way of feeling a 'distance' between one's self and the problem, a way of standing off and looking at one's problem with perspective". In agreement, Pierce (1985) claimed that most therapists aim to facilitate their client's insight and humour can contribute to this diagnostically: assessing what the client finds funny can illuminate any potential conflict or defences, and can also be used as a means to gain perspective and move to a different level of experiencing. This is in keeping with Allport's (1955:56) view that humour is "a remarkable gift of perspective" that allows clients to recognise the "disproportions and absurdities...in encounters with the world". Further, Bloomfield (1980:135) states, "humour is a direct expression of unconscious processes. It brings together opposites, highlights contradictions and shows up the absurdity of irreconcilable wishes. It is the paradox and the absurdity which makes us laugh".

O'Donovan (1985:62) also agrees that laughter is the physical manifestation of the realisation of a new perspective: "It is the joy of discovering that one's story can have a different ending, not necessarily in facts but simply in feeling." Additional

support for functions of humour that relate to insight include the ideas that it helps clients experience their feelings in a different way (Pierce, 1985); demonstrates in a positive way how problems may become solvable (Fry & Salameh, 1987); transforms old dysfunctional thinking into paradoxical thinking through an objective distancing (MacHovec, 1991); develops new insight and learning (Mann, 1991; Christie, 1994; Franzini, 2001; Barwick, 2012); eases tension by allowing clients to view their problems in a different way (Erdman, 1994); highlights clients' illogical or irrational thoughts by providing perspective (Sultanoff, 1994); creates distance and reflection upon, and hence relativises, pathology and illnesses (Fabian, 2002); and creates metaphors for transforming emotional experiences (Newirth, 2006a).

Lemma (2000) further comments on how humour influences reason through facing incongruity with amusement, resulting in more objective and rational perspectives. Not only can humour provide a new perspective, but also the new perspective with its sudden and unexpected nature can itself be humorous: "The biggest joke I shall ever experience is me. And once I am liberated from attachment to my ego and can see myself with humor, the humor in all experience comes easily" (Morreall, 2009:137).

Grotjahn (1971:238) claims that the therapist depicting humour gives an example of emotional freedom: "laughter in therapy is as welcome as any other sign of spontaneity, strength, mastery and freedom". Lemma (2000:81) states that by broadening and enhancing the complexity and flexibility of one's thinking, humour frees people from, for example, conformity, seriousness, reason and language, which in turn has implications for the role of humour in psychotherapy: "If humour encourages a loosening of the shackles of logical thought, it is in keeping with the aim of psychoanalysis, which encourages a similar loosening of associations".

Barwick (2012) points out that psychoanalytic theory suggests that life's difficulties, such as losses, frustrations and disillusionments, promote development by awakening people to the impingements of reality and challenging us to develop the capacity to manage better. In keeping, Christie (1994:485) draws on Searles' (1965) assertions, claiming that "humour is one of the great avenues by which disillusionment is sublimated in human development, and its appearance during therapy is one of the signs that patient and therapist have begun to master and integrate the disillusionment in their relationship".

MacHovec (1991:25) suggests that psychotherapy enables the individual to search for a truth of one's self, others and life situations. Humour, he says, takes away the threatening and painful nature of some truths, or as Kayser (in Simon, 1990) states, "reality...is destroyed by humor...The laughter which humor evokes is not detached but contains a certain measure of pain". Newirth (2006b) concurs, arguing that the core of humour and jokes consists of an acknowledgement of pleasure and acceptance of the unacceptable parts of us, which ultimately lead to psychotherapeutic transformation. This is in keeping with Lacan (in Dor, 1998) who viewed jokes as formed by combinations of metaphor, metonymy, condensation and displacement in order to assist addressing the limitations of the real. Such conceptualisations illustrate humour to have a somewhat nurturing or reassuring role, by conveying the idea that 'all is well' (Kris, 1938; Leech, 1968).

Poland (1990:198) further comments on how it is only once conflicts are analysed that clients are able to laugh at themselves and humorously appreciate irony and reflect on themselves:

"It is a capacity for sympathetic laughter at oneself and one's place in the world. Humor of this sort does not imply pleasure in pain but reflects a regard of oneself and one's limits despite pain. With such humor there is an acceptance of oneself for what one

is, and ease in being amused even if bemused...Such humor, often linked to an appreciation of irony, requires a self-respecting modesty based on underlying self-strength and simultaneous recognition of and regard for others”.

In considering the analyst's use of humour, Rose (1969:928) refers to the Fool in Shakespeare's 'King Lear', suggesting that it was through absurdity, caricature or “humor that, like some love, touches the truth lightly to avert madness” that enabled the analyst to reach those with ‘weak egos’. Bader (1993) research with patients diagnosed with obsessive-compulsive disorder found that humour furthered the therapeutic work by temporarily reversing and providing a distance between the patient and the subject matter or object. Bader's study can further be used as an illustration of how the therapeutic process can be facilitated: humour became a means through which the analyst conveyed information about their own mental state and attitude toward the patient which disconfirmed inhibiting expectations and thus increased the patient's ability to be self-reflective and to face painful affects.

In concordance, Mann (1991:166-167) reports on how his use of humour dispelled tension and allowed the client to explore what they might previously have bypassed, thus making “the seemingly impossible become surmountable”. Mann used group experiences, in which humour allowed members to express intimate thoughts by reducing anxiety, to conclude that humour indicated an evolution of transference in reaching new points of development and meeting resistances. Kisner (1994:142) also uses anecdotal evidence to show how “we could laugh...together, which helped [the client] to begin to differentiate between some of her own uses and abuses of humor. I learned a great deal about this topic myself from her and used this information to reflect on my own uses and abuses of humor in therapy with her and with other persons”. She further writes about a humorous experience in therapy, in which her

and a client “by displacement...were able to discuss the fears of losing precious belongings for which she’d worked so hard, the lack of choice and control about this happening to her and the anger she felt about the lack of caring and support that ‘they’ showed to her while taking from her” (1994:148), illustrating how humour can be used as a device to maintain focus on the topic at hand in order to resolve it. Other ways in which writers have supported the use of humour in deepening analysis include allowing the therapist to open up and thus better connect with patients (Ortiz, 2000) and introducing the possibility of pleasure within an intense, intimate moment which allows for the transformation of unacceptable aspects of both patient and analyst as they become joined within a broader human experience (Newirth, 2006b).

Existing research has highlighted the following ways in which humour can help deal with strong emotions: by enabling a detachment from traumatic thoughts and feelings (Kuhlman, 1994); as a source of ‘narcissistic gratification’, aiding recovery from the experience of shame, as a way of helping people get to feelings of disappointment or anger, and to help the client ‘lighten up’, particularly at the end of a session (Pierce, 1985); assisting the client to build self-confidence and self-esteem and thereby freeing the client from the erosive effects of stress, fear, guilt and anger (MacHovec, 1991); increasing psychological growth and a capacity to tolerate and analyse feelings and fantasies that have been warded off or compulsively enacted (Bader, 1993); as a ‘healthier’ way to deal with death-denial and to cope with unpleasant realities (Stephenson, 1993); to ease the mind, to cope with changes in clients’ lives or with the fear of the unknown, to ‘catch their breath’, to deal with tragedies, and as a defence mechanism that provides an outlet for escaping from negative feelings such as anger (Erdman, 1994); to overcome anxiety when the ego is beset with strange and frightening things (Lindenman, 1995); lowering the therapist’s

anxieties (Ortiz, 2000); a way of reducing stress (Franzini, 2001); and to integrate conscious and unconscious, concrete and symbolic levels as well as emotions such as joy and suffering (Fabian, 2002). Poignantly, Barwick (2012:173) cites Thurber: “Humour is emotional chaos recollected in tranquillity.”

What can be seen here is an overwhelming support for humour’s role in psychotherapy, however some have also demonstrated its more negative side. Fry and Salameh (1987), for instance have charted the contrasted characteristics of helpful and harmful humour in therapy. Further, Sultanoff (1994:34) depicted healthy humour as “that which brings people together, reduces stress, provides perspective, and feels good” and compared it to harmful humour, “which alienates others, increases hostility and ultimately feels bad”. Franzini (2001) points out that humour aimed at oneself is more likely to be healthy than that aimed at others, and acknowledged the importance of environmental conditions such as the nature of the relationship, timing and delivery.

There are further examples in literature of destructive humour, including sarcasm, obscenity, cynicism and irony, which convey destructive aggression, and can be hurtful and insulting, particularly when deriding those with physical or psychical problems (Reik, 1936; Christie, 1994; Fabian, 2002). There is agreement that such humour should be kept out of therapy (Salameh, 1983) as those that have been exposed to sarcasm or mockery in childhood could possibly be oversensitive to such jokes (Fabian, 2002).

Freud (1905:229) depicted humour as a displacement and deflection, “the highest of...defensive functions”. Whilst humour can provide a sense of safety by re-routing strong emotions, Pierce (1985:68) describes a scenario in which humour created a lost opportunity with a client: “humour was being used defensively” but also

maintained that “interrupting that defence allowed her to experience her underlying sadness”.

Kisner (1994:142) provides an illustration of how one of her cancer patients used sarcastic and defensive humour to her detriment:

“she would often use it as a way to make others comfortable with her cancer, which also made her angry as it tended to make her feel more isolated in the manner in which she’d use it. This use of humor – to keep people at a distance - was a problem that actually predated her diagnosis of cancer and was partly responsible for her failure to establish a satisfying intimate relationship”.

Barwick (2012) uses the term ‘deflective’ humour to describe that which distracted an individual away from negative feelings rather than transformed them. He argues that this kind of humour can lead to desensitisation, or carelessness, regarding one’s self and others. Mann (1991:164-165) also describes how a defensive use of humour disguised painful feelings for his client: “for her, the jokes inhibited insight and kept away the deeper feelings and understanding, but they also helped her function and keep some semblance of a normal life.” He reports a danger in humour’s propensity to provide a ‘false train’ away from anxiety or tensions, and provides a further anecdote in which, “the humour had not only disguised the real anxiety, but, like a good decoy, had successfully allowed him to distract himself, and me with him, from the issue he felt to be dangerous. In this instance the contagiousness of humour led to unproductive avoidance in the therapy”. Mann goes on to suggest that humour potentially obscures aggressive attacks, and in defence against anxiety, the client may ridicule their symptoms thereby evading the acceptance of help. Caution is also advised for those instances where the client feels obliged to laugh at therapist’s jokes, particularly when the client perceives the therapist to be making light of the client, and when the therapist is using humour as a form of self-exhibitionism, or as Kubie (1971:864) stated, “the most seductive form of transference wooing”.

There appears to be controversy in literature regarding the use of humour in psychotherapy. Some writers are clearly supportive of its potential, whereas others warn against its dangers (Ortiz, 2000). Even in those instances where the therapeutic humour is accepted (Grotjahn, 1957; Pasquali, 1986; Poland, 1990; Baker, 1993; Christie, 1994; Frings, 1996), there is still debate surrounding what kind of humour should be used, when, and how (Fabian, 2002): “Any clinical technique or medication that is powerful enough to be helpful is powerful enough to do harm. Humour again is no exception” (Franzini, 2001:184).

In exploring therapists’ attitudes toward the use of humour in psychotherapy, Block and McNab (1987, in Mann, 1991), found that therapists fell into either a strongly positive or strongly negative position with little middle ground. Mann (1991) concluded from this, the need for a flexible approach, with an understanding that humour has a place for some clients in therapy and not for others, and will also serve varying functions.

MacHovec (1991:29) suggested that:

“the diagnostic test of effectiveness is whether or not it facilitates a healthy, positive response, whether it is therapeutic. Minimally, the effect should be a chuckle or a laugh. Optimally it should reflect some aspect of insight or therapeutic gain such as helping to develop the ability to laugh at one’s self, adapt or adjust to the life situation, or soften harsh reality”.

The only author that is strongly against the use of humour in therapy is Kubie (1971) in which using humour in therapy is essentially forbidden. He highlights the aggression that humour is charged with, and claimed that even laughter is a means by which the patient seduces the therapist and subverts treatment. Humour, he maintains, reinforces defensiveness in both therapist and client and elevates the therapist’s narcissism: “Humor has its place in life. Let us keep it there by acknowledging that the place where it has a very limited role, if any, is in psychotherapy” (1971:866). In

response, Poland (1990) argues that this warning should not lead to the conclusion that all humour is wrong, and reminds us that the fool in Shakespeare's *King Lear* is the only one who is able to say to Lear what he could not hear from anyone else.

3.5 Comedy, tragedy, humour and terminal illness in psychological therapy

Lacan (in Zupančič, 2003:174) states that “tragedy is in the forefront of our experiences as analysts”, but there are also certain commonalities between therapists and comedians. The jokes, anecdotes, sketches and observations that comedians use, not only provide a particular kind of relief, but also facilitate a new way of looking at ourselves, events around us and other people, by confronting us with contradictions and incongruities. The same could be said of therapists. Whilst the therapist's role is not necessarily to entertain or amuse clients in the same way as the comedian, through their respective fields both encourage a certain re-examining, both rely on timing (the joke versus the psychoanalytic interpretation), and both find inspiration in what is flawed, lacking or painful.

Pierce (1985) argues that humour in psychotherapy assists clients to attain a sense of mastery over reality's impingements, which enables them to further extend this mastery to other arenas in their life which feel uncontrollable. This also has an effect in equalising the therapeutic relationship. Fabian (2002:407) for instance states that:

“Jokes may convey the point of a therapeutic conflict and relieve the transferential tension by introducing a relativizing moment, enhancing the reality principle – just as do well-placed anecdotes, stories or fairy tales...Humour strengthens the contact bridge to and the confidence in the therapist, that is, it strengthens the reality aspect of the therapeutic relationship, beyond transference, and the positive identification with the therapist.”

This is in agreement with Poland (1971) who, reporting on his own spontaneous use of humour, found that rather than derailing the therapeutic alliance, it reflected and strengthened the analytic work. There are a number of authors that concur with the notion that humour facilitates a greater recognition of the intimate relationship between therapist and client, enabling the client to see the therapist is not immobilised by the client's defences, and by becoming a marker of shared enjoyment within the alliance, establishing rapport (e.g. Pierce, 1985; O'Donovan, 1985; Mann, 1991; Bader, 1993; Goldin & Bordin, 1999; Oritz, 2000; Franzini, 2001). Newirth (2006a:566) refers to this as a process of 'symmetrising' the relationship:

“a merging or dedifferentiation of the unconscious experiences of both analyst and patient that results in a pleasurable moment of mutual identification, a diminution of the asymmetry of the roles of analyst and patient, and a symbol of the unconscious meanings of the transference-countertransference fantasy into the analytic dialogue”.

He claims that even in instances where this symmetrisation fails, there is the opportunity for “reparation and greater mutual understanding and connection”.

There is, however, noticeably little research exploring the relationship between humour, terminal illness and psychological therapy. That which does exist purports that humour is used to counteract the negative impact of death and dying, “we use humor because we see a situation that is so far beyond our control that there is little we can do but laugh” (Stephenson, 1993:173). The most notable work in the field of humour and terminal illness has been carried out by Allen Klein (e.g. 1989, 1998), self-confessed ‘Mr. Jollytologist®’ who travels around America giving keynote speeches and workshops on therapeutic humour. His work started when his wife was diagnosed with a rare form of cancer and died aged 34. He said that telling jokes and stories lifted not only his wife's spirits, but everyone else's, including his own. He claims that humour provides some freedom from the stressors of life, relief

from dark times, release of pent-up emotions, a change in the course of a situation, a vehicle that allows a view outside of immediate problems, a way to gain power over losses, encouragement in the face of setbacks, as well as a reduction of denial and anger. In these ways, he argues that humour ultimately decreases the negative impact of life events, providing a moment of respite and helping intolerable situations become more tolerable, for both patients and those around them.

Thorson (1985) and Kisner (1994) both refer to their experiences of humour in group therapy sessions. Thorson described humour as functioning as a lubricant to displace grief, distract others from its grim realities and minimise death's impact on other group members. Kisner draws attention to clients who were angry at society as a result of their diagnosis, and hence felt detached from others, using sarcastic humour that excluded group facilitators. According to Kisner, the 'us-them' split this implies suggested that their humour represents how separate their cancer makes them feel from the rest of society:

“because of [the client's] tendency to feel victimised by anyone without a diagnosis of cancer, the group leaders were exclude by his bits of caustic humor. I chose not to attempt to make a humorous response because of the likelihood that he would misunderstand it and feel further distanced from me...Another example of humor from M., an angry group member, seemed more like an attempt to include everyone in the group, inclusive of the leaders into an experience that all could share. I could respond with a humorous abstraction that made reference to a person's attempts to find the right way to do something”

(Kisner, 1994:149-150).

Literature has also referred to humour's potential as a coping mechanism to help professionals and caregivers deal with the intensity of feelings associated with terminal illness, such as for stress reduction and preventing burnout (Fry and Salameh, 1987), enabling professionals to meet their own self-care needs (Erdman,

1994), and as a means to allow others to confront arising existential issues and the concurrent intensity of feelings by providing a more balanced outlook:

“To devote one’s career to the care of persons with cancer, which brings up some complex emotional and medical treatment issues, is often overwhelming. In addition, the frequency of being faced with watching patients whose death is painful raises a variety of universal (existential) concerns around the caregivers’ own morality, sense of helplessness, and purpose in their professional lives. Humor...has become an essential part of the healing process for staff, directly and indirectly for the patients and their significant others”

(Kisner, 1994:152).

3.6 Conclusion

In considering the opening question to this chapter, what has been uncovered here reveals a plethora of disparate research into each of these individual elements, as well the relationship between any two of them: humour and terminal illness; terminal illness and psychological therapy; and, humour and psychological therapy. However, what appears to be missing is what emerges when all three elements appear together, which, although anecdotally present, is significantly absent from empirical research.

The relationship between tragedy and comedy as explored through the literature presented here strongly highlights the human predisposition to combat tragedy through comedy. However today, we do not live in a world of Gods and Kings and so the word ‘tragedy’ is rarely used for something that is actually ‘tragic’ as it was originally defined. It has become a word that is overused and often misused and it is heard of or read it in newspapers almost daily. There is a possibility that this study is guilty of doing the same in using the word ‘tragic’ in reference to terminal illness, which is something to be borne in mind. Having this awareness will hopefully discourage the propensity to fall into the common perception that Lemma (2000:43) has summarised:

“A painful psychotherapy session is one worth paying for. If we laugh we harbour, both as patient and as therapist, the secret concern that no ‘work’ has been achieved. Bound by the belief that the road to greater insight is earned through cathartic expression of our emotional pain, humour is all too often dismissed as of little therapeutic import”.

Considering the ‘tragic’ then, death, “the one destruction that is certain, universal, unexceptional, the one Absolute that suffuses finite existence” (Eckardt, 1996:10), could be seen, in keeping with Nietzsche, as the final incongruity of life. Since comedy deals with the incongruous, death may be also studied from this point of view. Changes in attitudes towards death are seen throughout history and their effects upon society, different professional groups, individuals and their families can be demonstrated. The image of a ‘natural’ death in old age after years of good health is a recent ideal. Reck (1977:317-318) contends that dying provides the possibility of growth, both for the dying and the surviving people around them. “A basic value in life”, he states, “is growth, and growth is possible for the dying no less than for the nondying. Worse than dying is that death in life, which so many of the nondying, closed to growth, live”.

Similarly, although humorous responses sometimes represent an attempt at denial, this is not always the case, and at times a temporary degree of denial may be adaptive “by conceptually resolving the incongruity in its capacity to tolerate the pain without extolling it and retaining the sense of selfhood in a world of pain and ambiguity” (Lemma, 2000:43). As Schelesinger (1979) points out, a tragic response could also be said to involve denial of impotence by conferring an illusory sense of self-importance by viewing defeat as somehow lending meaning to the conflict.

This literature review reveals that there has been an increasing volume of work that is largely evaluative and attempts to justify humour’s role and potential in the psychotherapeutic context. However, prevailing research mainly focuses on the

implementation of humour appearing as ‘how-to guides’ indicating how it should or should not be used, or whether or not humour should be used in psychotherapy indicating potential therapeutic benefits or caveats associated with its applications (Franzini, 2001). Cutting across the varied conceptualisations of humour reviewed in this chapter is the positive value of humour and the belief in humour’s healing ability has led to a growth of ‘laughter clubs’, laughter therapy and clowning, where clowns visit hospitals and hospices to cheer people up (Killeen, 1991). Humour, used judiciously, and for the benefit of the patient and not the therapist’s own self-aggrandisement, has been depicted as a powerful, yet subtle, form of communication which may ease the difficult exchanges that take place with a terminal diagnosis (Warner, 1991; van Wormer and Boes, 1997; Du Pré, 1998). It has been shown to contribute to the healthy functioning of society and a critical tool that aids learning and possibly promotes individual and social change. However, if it is so central to cognitive, emotional or social adaptation, the ‘critical’ role it plays in our lives must also be looked at, particularly the role and potential it has in the context of the therapeutic relationship. There has also been literature that has addressed the negative side of humour as an intervention that lacks sympathy or is insulting. Ortiz (2000) however, reports that the findings of humour research are difficult to condense into an unequivocal recommendation.

There has been little research regarding humour in terminal illness, however (Killeen, 1991). Klein (1989) is one of the few authors to examine humour and the dying process. Joking about death and the ambiguity surrounding death diminishes the mystery and decreases the fear, oppression, anxiety, and threatening nature of death. Humour also makes it easier to bear the unbearable: “Humor may not alter the fact that we die; but it helps us live with it and deal with it” (1989:183). He states that

death is neither intrinsically sad nor funny, however, the period of time leading up to death is stressful and communication can be difficult. At times such as this, it is easy to lose sight of the benefits of humour in lightening interactions and providing stress relief. Klein points out that laughing at death provides a triple pleasure: “the pleasure of the joke itself, the malicious joy of laughing at death’s expense, and the pleasure of taming Death and fraternizing with him” (1989:188).

Making fun of death, and specifically one’s own death, helps one face death by accepting the insignificance of life, while diminishing the awesomeness of death (Thorson, 1993). Thorson (1993) shows that such a displacement often can be seen in humour at another’s expense, and so humour about death may be used as a hostile attack on death. For those living with a terminal illness, it can also provide balance: a way of focusing on the problems experienced when living with cancer and diverting attention away from issues of mortality, aloneness and worry (Buckman, 1994). In accordance, Gruner (1997) purports that joking about death offers superiority over death, which, while transitory, can lessen the fear of the inevitable; and Paskoff (1998), examining terror and comedy, states that by turning the terror of death into comedy, one can confront and conquer death symbolically, if temporarily.

While humour can be useful in dealing with the pain, anxiety and inevitability of death, caution is advised. Humour and death are often seen as mutually exclusive experiences, and laughing at death can be seen as in bad taste (Klein, 1986), or uncaring (Thorson, 1993). Discomfort or confusion can result from a forced attempt to look at the “badness” of death in a “good” way through joking or humour (Mager & Cabe, 1990). Further, given the nature of terminal illness, there are good days and bad days; days when humour is essential and days when it is intrusive (Klein, 1989). It requires sensitivity and caring to adapt to the mood of the day, or even the moment.

The domination of psychoanalysis in the fields of both humour and terminal illness is noteworthy, and calls for a need to strengthen, develop and enrich the exploration of these phenomena in therapy without any set theoretical position. By qualitatively exploring therapists' experience of humour as it arises in sessions with clients diagnosed with terminal illness, this research will hopefully contribute to the existing literature on comedy and tragedy in relation to psychological therapy and counselling, as well as humour and death. In doing so, it will hopefully address a broader question of how lived experience is researched, with wider implications for both research and therapeutic practice.

Chapter 4: Methodology

“What we choose, we value simply because we have chosen it (and apparently we remain scot-free at any moment to nonvalue it by simply un-choosing it)”

- Polanyi (1975:2)

4.1 Introduction

Existing literature on humour has focused on theories that attempt to explain it, producing almost manualised guidelines of its processes, and has highlighted great debate in its effectiveness. Very little research however has sufficiently explored psychological therapists’ experience of humour, particularly in sessions with clients diagnosed with terminal illnesses. As such, the aim of this study is to explore therapists’ subjective and lived experiences of their own and their terminally ill clients’ humour as it arises in sessions to address the overarching research question: “How do psychological therapists experience humour in sessions with terminally ill clients?”.

The close relationship between methodology and philosophy has been explored by Carr (2006:422): “methodology cannot be derived from research but instead has to be grounded in that form of *a priori* theoretical knowledge usually referred to as ‘philosophy’”. With this in mind, two key positions need to be borne in mind: the epistemological, which refers to the knowledge pursued through this research; and the ontological, which regards the philosophical notions of being, existence and reality. This chapter therefore considers theory, philosophy and methodology to explore how most effectively, if possible at all, to research experiences of humour and their relation to terminal illness in the therapeutic encounter. Specifically, it examines a variety of ways to collect and analyse research participants’ self-identified experiences and their epistemological assumptions about

the phenomena in relation to the concepts of humour and terminal illness explored in the previous chapter.

The implications of researching humour were briefly discussed in Chapter 2, which alongside the Literature Review (Chapter 3), raised primarily three core aspects that are important to consider in choosing a suitable method for the research question:

1. The method should, as accurately as possible, capture a rich enough description of therapists' experiences.
2. The method ought to allow for the contextual nature of humour, including the context of society, temporal context, and also the context of the individual and the relationship – that is, the relationship between humour and terminal illness, the relationship between therapist and client, but also the relationship between researcher and researched. This last point is particularly important because it felt pertinent to acknowledge the researcher as part of the research - especially given personal experiences of being a therapist experiencing humour with terminally ill clients – but also a method that would acknowledge this without pulling the research in a way that bolstered the researcher's views over those of the participants.
3. The method should maintain as much of the vitality of humour, spontaneity and playfulness of humour as possible.

The approaches considered below for the suitability of this particular research, and to ascertain the extent to which they meet these three considerations, include quantitative research methods; interpretative phenomenological analysis (Smith, 1996; Smith et al., 2009); discourse analysis (e.g. Foucault, 1984); heuristics

(Moustakas, 1990) and narrative analysis (Labov, 1972; Ricoeur, 1984; Bruner, 1991).

4.2 Quantitative research methods

In considering the aims of this research, it is necessary to ascertain whether a quantitative or qualitative method would be most suitable, and to consider the ontological differences that these two methods offer in terms of how the individual or self is understood and constructed. Guba and Lincoln (1994) suggest that in order to do this effectively, an exploration of the distinctions between positivism, the philosophy underpinning quantitative, scientific approaches, and interpretivism, its alternative, is worthy.

Positivist researchers work from a perceivably dualistic ontology in which reality, or the phenomena being considered, is distinct from and external to the subject, or researcher. Statistical and mathematical techniques are adopted to provide a scientific and definitive testing of hypotheses, in keeping with a nomothetic epistemology that portrays knowledge as objective and measurable to determine external realities and hence provide context-free and universal explications (see for example Carson et al., 2001). As Skedi (2005) points out, the positivist discourse of consistency and non-contradiction establishes structured categories, identifies causes, collects facts and manipulates variables in controlled conditions to establish verifiable ‘truths’ in methods that are well defined, routinized, and ultimately, replicable.

Interpretivism on the other hand, adheres to an idiographic epistemology that purports ‘truths’ to be relative, and reality and knowledge to be intersubjective and contextual, with an underlying belief that social action has meaning. Researchers use qualitative methods to interpret phenomena and maintain an awareness of reciprocal and interdependent relationships between the researcher’s actions and the research

objects. The interpretive epistemological position hence calls researchers to acknowledge the lived experience of themselves and of the research participants, and as purported by Guba and Lincoln (1994), not to base knowledge on measurable phenomena or observable experiences, but on beliefs, values, reasons and understandings.

In determining a suitable method, this research has to acknowledge that both positivism and interpretivism seek to enhance our shared understanding of the world. Whilst both appreciate the role of bias in the research, the quantitative methods drawn from the positivist paradigm appear to stand alone from those that are more interpretive, where the former quantifies experience (De Castro, 2003) and the latter explores it and acknowledges the existence of ‘multiple realities’ (see for example, Kvale, 1996; Voce, 2004). Quantitative research therefore, is arguably reductionist in that it appears to summarise descriptions for a group of people by closing down or distorting phenomena through measurement and quantification rather than being open to participants’ rich descriptions of their lived experiences. It was felt that research grounded on positivism, with the assumption that reality is easily accessible and therefore graspable, would run the risk of abstracting the experience of humour and terminal illness. Positivistic research could potentially be derivative and narrowing, if not closing down completely, possibilities through pre-established categories and pre-defined criteria to measure participants’ experiences, with no space for inconsistency or uncertainty in responses. However, from the Literature Review chapter, it is possible to see that it is the very inconsistencies of perspective, language and action that was found to be an essence of humour, as purported, for example, by those authors such as Reik (1936) who ascribe to the incongruity theory.

Interpretivism's acknowledgement of a dynamic, complex and relational reality appears to lend itself well to the current understanding of humour, not as something that can be empirically measured and validated, but something more transient, spontaneous, contextual and intersubjective. Therefore, in staying open to exploration and possibility, a qualitative method was deemed the most applicable to that aspect of humour which may be lost in the speaking of it, to the uncertainty that an experience of humour which may never fully be uncovered, and importantly, to the acknowledgement of the phenomena as an individual yet dialogic experience that may not be easily generalised.

A further consideration of a suitable method regards its aim to unearth general, or 'nomothetic' aspects of phenomena, compared to more particular or 'idiographic' essences. In qualitative research, nomothetic methods are likely to disregard the more specific or particular details that research would uncover in favour of more generalised, whilst eidetic, understandings of participants as a group to effectively "come up with a typical essence" (Giorgi, 2008:37). Considering the epistemological underpinnings of this particular research, it was felt that a method that explored both the individualised experiences of humour and terminal illness, as well as the relationship between this and the more general contextual notions of these phenomena, would be most suitable. Here, Finlay's (2009:10) explanation of Halling's (2008) middle ground is worthy of mention: researchers can be focused on both the particular and the general by "moving back and forth between experience and abstraction" by first examining particular experience, then assessing common themes, before looking at the larger philosophical and universal implications.

Finally, the Literature Review showed that researching humour is challenging due to its very nature (e.g. Lemma, 2000), and therefore some consideration must be

given to the nature of knowledge, namely the differences between tacit and explicit knowing and how this might implicate researching such an experience as humour. Polanyi (1958) first indicated that tacit knowledge refers to that which we know but cannot explain symbolically through text or language, or as he states, we “know more than we can tell” (Polanyi, 1967:18). Whereas explicit knowledge is relatively objective, easily transferred and can be deduced logically, tacit knowledge is argued to be intuitive and consisted of values, beliefs, ideals and experiences, and therefore difficult to articulate and share. This description of knowledge fits well with the description of humour in Chapter 3, as being something that is difficult to verbalise (e.g. Lemma, 2000). The requirement for a method that effectively addressed the tacit dimension of an experience gave further credence to the choice of a qualitative methodology that captured a rich description of participants’ lived experiences. Hence, a qualitative method, overall, better suits the three core considerations of finding a suitable method: the ability to establish a rich description of experiences, flexibility, and the acknowledgment of contextuality and relationship.

4.3 Interpretative phenomenological analysis (IPA)

With the intention of this research being first and foremost the exploration of therapists’ experiences of humour in sessions with terminally ill clients, and the appropriateness of a qualitative method, it was felt that phenomenology would be a suitable starting point. The aim of phenomenology is to ascertain the meaning and essence of experiences through the researcher's work in capturing, understanding and reporting participants’ own individual construction and shared understanding of reality and worldview (Taylor & Bogdan, 1998; McLeod, 2001), “how they perceive it, describe it, feel about it, judge it, remember it, make sense of it and talk about it with others” (Patton, 2002:104).

Using qualitative methods, phenomenological researchers gather descriptive, in-depth and embodied descriptions of phenomena as it is concretely experienced: “Phenomenology is a low-hovering, in-dwelling, meditative philosophy that glories in the concreteness of person-world relations and accords lived experience, with all its indeterminacy and ambiguity, primacy over the known” (Wertz, 2005:175).

Interpretative phenomenological analysis (IPA) informed by phenomenology, hermeneutics and idiography is a systematic, qualitative analysis that aims to explore the essence of individuals’ conscious experiences of phenomena (Smith et al., 2009). Rather than speculating on causes of experiences, IPA aims to describe it as interpreted by both participant and researcher. In analysing data, the researcher is encouraged to suspend their own preconceptions to allow for a fuller focusing on the participant’s experience, and works from a ‘bottom-up’ stance in which codes are generated from the data rather than being based on pre-existing theories that are applied to the data. Emergent codes are formed into themes and then superordinate themes that consist of recurring patterns of meaning, and in the researcher’s attempt to explore the meaning of participants’ exploration of meaning of the given phenomena, a ‘double hermeneutic’ is created.

In responding to Husserl’s call for researchers to “go back to the things themselves” (Smith et al., 2009:1), IPA initially appealed as a potential method with which to explore the experiences of humour and terminal illness; it was considered to have clear guidelines coupled with a solid methodological grounding, which informs both the quality of interviews as well as the sensitivity and depth of analysis. IPA therefore clearly meets the requirement for the method to capture data that would be rich and eidetic, and to some extent also allows for the subjective and contextual

nature of humour to emerge. To what extent then does it acknowledge the relationship between researcher and participant?

Finlay (2009) indicates that a key element of IPA is for the researcher to set aside external frameworks and preconceptions about the trueness of a phenomenon. However, whilst the implications of researcher subjectivity are acknowledged, as is phenomenology's characteristic realisation of the intersubjective relationship between researcher and researched, there is debate surrounding the extent to which researcher subjectivity can and should be deployed in research (Finlay, 2009). Consideration of the notion of *epoché*, or bracketing, and subjectivity is crucial for this study, particularly due to the researcher's personal experiences of providing therapy to terminally ill clients.

Some researchers (e.g. Ashworth, 2007) uphold the view that they should maintain neutrality through an attitude of *epoché*. Here, researchers build awareness, identification and set aside presuppositions of previously established theories or explanations, participants' claims of truth or falsity, and the researcher's personal views and experiences, all of which potentially obscure descriptions of the phenomenon. Giorgi (1994) posits that in this way, the researcher is more able to look at the data with relative openness and "is prepared to admit and deal with imperfections in a phenomenologically messy and methodologically imperfect world, but still believes that objectivity is worth striving for" (Patton, 2002:93).

In line with Halling et al. (2006) however, it is argued here that it is not possible or even desirable to set-aside or bracket researchers' experience and understandings. Indeed, Finlay (2009:17) suggests that researchers ought to place a "critical self-awareness of their own subjectivity and how these might impact the research process and findings" in order to better distinguish what is the researcher's from what belongs

to the researched (Gadamer, 1975). In this way, the research becomes dialectic and intersubjective – just as humour and psychotherapy are – or as Finlay (2003:108) writes, “a process of continually reflecting upon our interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings”. The key to reducing a preoccupation of the researcher’s own emotion and experience, which could pull the research in a direction which bolsters the researcher over the researched, lies possibly in embracing the intersubjectivity in a fundamentally relational approach which maintains a “reciprocal insertion and intertwining of one another” (Merleau-Ponty, 1968:138). Data collected in this way would therefore be more co-created. Critically, the necessity for IPA researchers to bracket their experiences was felt to jar with the key aims of this study.

Lastly, a large number of qualitative research methods ascribe to a fundamental descriptive reflection of a phenomenon (Wertz, 2005). Within these methods, there are variations as to the extent in which the focus is on a general description of a phenomenon, say ‘humour’, or on expounding a more individual experience. Typically, phenomenological researchers reflectively analyse and synthesise concrete descriptions, rather than explanations, of synthesised accounts. Themes are identified, which enables the researcher to go into a more interpretative dimension beyond the surface of explicit meanings into more implicit intuitions.

Descriptive phenomenological researchers (e.g. Giorgi, 1985), inspired by Husserl, aim to “reveal essential general meaning structures of a phenomenon and stay close to what is given to them in all its richness and complexity” (Finlay, 2009:10). In contrast, interpretative phenomenological researchers (e.g. Smith, 2007), inspired by Hermeneutic philosophers, maintain that all understanding is an inescapable entrenchment in a world of language and social and historical

relationships. What we experience has already been interpreted, and interpretation therefore is considered an inevitable structure of our existence as beings-in-the-world (Heidegger, 1927/1962).

Given the nature of the phenomena under question, it is potentially helpful to see description and interpretation as a spectrum. Langdridge (2008), for instance, argues that separating the two opposes the fundamental phenomenological foundations. In keeping, Van Manen (1990) suggests that a stronger element of interpretation is needed when description is stationed by expressions such as non-verbal signs, actions, art and text, and highlights the difference between interpretation pointing to something versus pointing out the meaning of something from an external framework. Ricoeur (1970) makes similar distinctions between ‘hermeneutics of meaning-recollection’, which provides a greater understanding of the analysed phenomenon in its own terms, and ‘hermeneutics of suspicion’ which need deeper interpretations to go beyond the surface. Wertz (2005:175), in commenting on the former, states: “‘Interpretation’ may be used, and may be called for, in order to contextually grasp parts within larger wholes, as long as it remains descriptively grounded.” The nature of humour, as has already been established, shows that it can indeed be mediated in expression and not just language, and in exploring humour’s role in terminal illness, a method which challenges surface accounts and therefore utilises description *and* interpretation, rather than just interpretation as in IPA, would be more suitable.

Overall, whilst IPA met the requirement for the chosen method to effectively explore the rich description participants might offer, it was felt that the rigid structure of conducting the research and extracting themes seemed to conflict with the way in which previous writers describe the spontaneous, creative and playful nature which humour seems to inhabit (e.g. Koestler, 1964; Winnicott, 1971; Pasquali, 1986;

Christie, 1994; Fabian, 2002). The means of analysing the data through IPA potentially fails to allow for the intricate role that language has to play in the formation of humour; and further, IPA was not deemed to give enough consideration to the cultural, historic, linguistic or relational contexts that appeared so important when working with humour and terminal illness in psychotherapy. As such, IPA was not considered a suitable enough method to explore the research question.

4.4 Discourse Analysis

Discourse analysis (e.g. Foucault, 1984) was a further qualitative method considered for the exploration of therapists' experiences of humour in working with clients with a terminal illness. Fairclough (2003) and Flick (2006) indicate that discourse analysis critically focuses on issues such as the construction of social reality and how it is described through language through an exploration of the subject's position and their negotiation with power and ideology within a given discourse. In situating language in social, cultural, political and historical contexts, discourse analysis assumes that "examining it can help reveal layers beneath taken-for-granted meanings and practices", which in turn, "displays forms of control, persuasion and manipulation in the meanings inherent in the discourse" (Bradbury-Jones, Irvine & Sambrook, 2007:83). This seemed pertinent in considering the ability for a method to challenge surface accounts explored previously, particularly given Freud's (1905) depiction of humour as a displacement and deflection.

Discourse analysis' engagement with and intense sensitivity to power relations potentially highlights imbalances and subtle forms of oppression previously overlooked, which had initial appeal in considering Kisner's (1994) perceptions of society's reaction to terminal illness, as well as the nature of humour depicted in the superiority theory explored in Chapter 3. It was also felt that discourse analysis met

the requirement to gather a rich description of participants' experiences and allowed for the contextual nature in which humour arises, as it would acknowledge the milieu in which participants exist, with a view that the self is created through language and interaction with others in the world. However, it is considered by the researcher to also be a method that does not necessarily see us as subjects capable of creation independent of the discourse in which we stand. As Madill and Doherty (1994:266) state, in a pseudo-objective manner, discourse analysis potentially "[negates] the personal agency of individuals through tying subjectivity so closely to context". Ultimately, while discourse analysis would be helpful in explaining the nature and the construction of a joke for example, humour's playfulness and spontaneity run the risk of getting lost with this method. Discourse analysis potentially refutes our ability to construct language and one's own meaning, whereas the aim of this research is to explore the experience of the nature of humour and jokes in the intricate gap between life and death, into which people dive and something new is created. The nature of a joke is, in essence, the playful creation of something new, which discourse analysis does not allow for.

Overall, whilst discourse analysis would provide a valid and interesting means to explore the way in which participants might use language to understand their experiences of humour and terminal illness, it was felt that it would be inappropriate for the aims of this research, which is to gain a broader picture of the experience of humour and terminal illness in the psychological therapies. Further, discourse analysis does not necessarily allow for the integration with a phenomenological position, in that personal meaning making may be under-valued in this particularly social-constructionist approach. For these reasons, discourse analysis was discounted as an appropriate method for this study.

4.5 Heuristics

On the other side of the spectrum, Moustakas's (1990) heuristic research, which focuses on the discovery of nature and meanings of human experiences, was considered as a suitable method for the research question and aims of the enquiry. Given heuristic's acknowledgement of the role of the researcher in the exploration, it is a highly subjective method and one that stands in stark contrast to discourse analysis for this reason.

Moustakas (1990) indicates the essential element of the heuristic method as being the researcher, and is therefore autobiographical in that both researcher and participant explore phenomena as a means to develop self-knowledge. With a requirement for the researcher to have first-hand experience of the phenomena, this method allows for a dialogue with the self and follows a course of initial engagement and then an immersion in the research question, followed by the phase of incubation and then illumination, in which new meanings are elicited into conscious awareness, thereby allowing for a universal significance through dialogue with others into a creative synthesis (Moustakas, 1990).

With the heuristic focus on meaning and the relationship between researcher, participant and phenomenon, and the creative nature of the method that would allow for the playfulness and spontaneity of humour, heuristics had initial appeal as a suitable method. However, at the point of conducting the research, the researcher's own personal experience of being a counsellor working with terminally ill clients was not sufficient enough to meet the heuristic requirement of having substantive experience of the phenomena being explored.

Further, it was felt that heuristics, in bolstering the researcher's experience above that of the participant's, runs the risk of losing some of the relational aspects of humour and terminal illness, particularly the cultural and historic context in which the

self – either researcher or participant – is experiencing. In other words, heuristics potentially quashes the possibility of the emergence of different unique meanings, which is contrary to the initial aims of the research to remain open to alternatives. Lastly, in being primarily autobiographical, heuristics did not fit well with humour's dialogic nature. The literature review repeatedly illustrated (e.g. Freud, 1905; Erdman, 1994; Franzini, 2001; Newirth, 2006a) humour's essentially relational and dialogic nature. Though the nature of a 'solipsistic' humour is worthy of greater consideration elsewhere, the argument here is that humour only becomes humour through somebody else hearing it and their relation to it. Humour is, therefore, a dialogue between a speaker and a hearer, and potentially in solipsistic humour, a relationship that emerges from the inner dialogue. A heuristic methodology was not felt to address sufficiently this dialogic nature of humour, or potentially the dialogic nature of being a therapist working with such clients.

4.6 Narrative Analysis

Of significance is narrative analysis, which was felt to not only meet the three core requirements for a suitable method, but also to speak to a number of characteristics contained in humour, terminal illness and psychotherapy: temporality, contextuality and relatedness. Using a narrative method was also felt to be harmonious with the acknowledgement of the role that ancient Greek tragedies and comedies have played in shaping current thought on terminal illness and humour. Considering the key epistemological and ontological considerations explored above, it was felt that an in-depth understanding of humour and terminal illness in psychotherapy can only be achieved by obtaining a detailed account of psychotherapists' lived experiences, and with it their unfolding sense of understanding and the related factors that contribute to the phenomena under investigation. It is perhaps important here to return to

Heidegger's depiction of life as embodying a distinctive temporal structure, and the extent to which life therefore may have a narrative structure (Guignon, 1998).

Heidegger (1927/1962) identified human beings as thrown into social, cultural and linguistic contexts and therefore unable to completely extricate from these constraints. Polkinghorne (1988) interlaced these themes together into a narrative construction of reality in which the essence of human existence is an on-going meaning-making process, ordered and expressed according to linguistic characteristics. Just as Heidegger (1927/1962) depicted the interacting trinity of past, present and future, Polkinghorne (1988:126-7) depicted a narrative's ability to "structure and organise time according to hermeneutic principles...through multiple levels of interpretation". The social, cultural and linguistic domains are thereby used to understand ourselves, others and the world as meaningful and stories are models for the link between actions and consequences: "narrative is the discourse structure in which human action receives its form and thorough which it is meaningful" (Polkinghorne, 1988:135). In this way, narrative can be seen to reject ideas of fixedness and permanence, which resonates with both the fleeting nature of humour, and the constraints of a terminal diagnosis. The view that self-identity is created through an unfolding narrative therefore gives credence to the dismissal of objectively measuring lived experiences through positivist methods, and instead acknowledging the construction of experiences as intrapersonal and co-constructed by one's social and cultural context (Golomb, 1995; Spinelli, 1996; Guignon, 2002; Guignon, 2004). As Polkinghorne states, "if the unity and uniqueness of the self is achieved through the process of narrativity and if one conceives of one's particular existence as a special story and not as a physical or mental thing then more adequate, hermeneutically oriented research tools will be needed" (1988:151).

Narrative analysis is based on three key tenets: the centrality of stories as meaning-generating activities; the facilitation of awareness and understanding through stories; and, the storied nature of human existence in which reality is a narrative construction (Ricoeur, 1984; Polkinghorne, 1988; Bruner, 1991; McAdams, 1993). Narrative analysis therefore aims to explore and understand the multidimensional and dialogic processes of individual experiences in collecting, analysing and contextualising human stories: “people create stories out of the building blocks of their life histories and culture, and at the same time...these stories construct their lives, provide them with meaning and goals, and tie them to their culture” (Lieblich et al., 1998:168).

Murray (2003b) argues that through the stories we tell others and ourselves, we shape our identities and interpretations of the world, and in this way, narrative can be seen as a reflexive method exploring both the events and subjective experiencing (Angus & McLeod, 2004). Bruner (2004:3) offers a similar explanation of the way in which “we constantly construct and reconstruct ourselves to meet the needs of the situations we encounter”. The exploration of the given phenomena therefore, is particular to the specific time and context in which the story is being told, just as humour has been described previously.

There exists a range of narrative methods, and although interlinked, each has different outcomes and accomplishments (Brockmeier & Harré, 2001; Gimenez, 2010). Structural and event centred approaches, such as Labov’s (1972), focus on the interaction and changeability of constituting elements of narrative, in comparison to Ricoeur’s (1984) experienced-centred approach, and lastly Bruner’s (1990) functional narrative analysis, which focuses on the purpose of narratives in a more pragmatic way. In determining which of the variety of narrative research methods to use and

which potential outcome is most valid to the research question, it is worth exploring these in greater depth.

4.6.1 Structural Narrative Analysis

Labov's (1972) approach focuses on the sequential arrangement of narratives. He illustrates a number of different types of clauses that maintain temporal sequence, the structure of which determines the function of the clauses, namely the 'abstract' at the beginning announcing a story will be told, 'orientation' which depicts the context, 'complicating action' which orients the listener to the series of events, 'evaluation' which portrays the narrator's attitude, and 'result' or 'coda', in which the story ends with resolution and returns to the present through the narrator's verbal perspective at the moment of narrating. This focus on the beginning, middle and end of stories resonates with the nature of jokes, terminal diagnoses and psychotherapy, all of which are arguably structured in the same way.

A further approach to narrative analysis that was considered for this research was that of Ricoeur (1984), who purports that it is through the creativity of language that the human subject is revealed, and the self and therefore life, is like a text unfolding into a meaningful story articulated in and through language. The sequential nature of life is thus not only characteristic of humans, but also what makes us human (Ricoeur, 1984). The understanding of an individual through looking at the story harkens back to Saussure's (1916/1966) claims that a story needs to be decoded to be understood.

Walsh (2003) points out that Ricoeur's narrative approach weaves together St. Augustine's analysis of time and Aristotle's depiction of emplotment in presenting a self that is understood through 'mimesis'. He portrays narrative as a means by which a meaningful story is created through the gathering of life's events, actions and

desires, the configuration of which is through emplotment. Grasping and understanding these as a meaningful whole occurs through plot which, according to Ricoeur (1992), imitates action. Ricoeur further draws comparisons between the narrative and metaphor in allowing a self to emerge into the world outside of direct description. Through narrative, he claims, the temporal dimensions of human existence, including action and temporality, are illuminated.

More than Labov's approach, Ricoeur can be seen to acknowledge the cultural and temporal context and nature of action, and the relatedness between a past that is always in relation to the present, and a present that is always in relation to what is hoped for in the future. The configuration of the activity gives the sense of followability and thus conclusion, in which there is a resolution of the problem unfolded in the plot. The text is then completed in its fusion with the reader, who in turns experiences a change of character through the cathartic effect of learning his actions through narrative. The approach therefore gives import to the interaction between speaker and hearer, writer and reader (Ricoeur, 1992).

Examined in more detail, both Labov's (1972) and Ricoeur's (1992) approaches consider narratives to be isolated and independent versions of past experiences, however in doing so, potentially overlook the sociolinguistic contexts that frame and sustain the narratives (Gimenez, 2010). The prescriptive nature of these structured approaches arguably reduces the potential for other possibilities in overly concentrating on subjective experiences at the expense of a socially constructed subject. With this being the main focus, the impact of the interaction between researcher and participant, and storyteller and listener, is neglected (Andrews et al., 2008). The unity and coherence that is assumed in both of these approaches is potentially in contrast to a postmodern philosophy – and arguably, too, the nature of

both humour and terminal illness – in which it is the incoherence and disunity that is so central:

“Post-modern thinking would tend to favour diversity, multiplicity and uncertainty, over system, ideology and generalisation; play, decoration and idiosyncrasy, over coherence and transparency; irony and questioning, over received wisdom or established authority...Subject to contingency and, in the end, to our own deaths, that over which we have no control, it would see ‘autonomy’ and ‘wholeness’ as illusions; we are displaced, split, fractured and changeable, our messages to each other never leading to any finally consensual meaning, always open to slippage and variable readings.”

(Loewenthal and Snell, 2003:5)

Essentially, “narrative constantly reproduces the phantom of a whole, articulated system, where even the concept of a system is a product of a narrative” (Roof, in McQuillan, 2000:213). It is believed instead that incoherence and incompleteness can potentially produce a narrative, and the diversity, multiplicity, uncertainty, play, decoration and idiosyncrasy depicted above, are all quintessential to the subject being researched here. The ‘slippage’ is indeed often the humorous. Further, in considering the use of a structural approach to narrative, Heidegger’s (1971:5) comment is pertinent: “the language of the dialogue constantly destroyed the possibility of saying what the dialogue was about”. What comes to mind here is the quote from Dixon (1980:287) explored in Chapter 2: “pontifications about humour are death to amusement”. Therefore, the prescriptive nature of Labov’s and Ricouer’s approaches and their failure to sufficiently acknowledge the contextual and relational nature of the story being told, ensured that neither of these would suit the nature of this research. One of the authors to address these shortcomings was Bruner (1990, 1991), whose functional approach to narrative analysis was fundamentally found to best harmonise with the intentions of this study.

4.6.2 Functional Narrative Analysis

Epistemologically, Bruner (1986) distinguished between a logico-scientific mode of knowing to a narrative mode of knowing (Czarniawska, 2004). The latter organises experience through the way in which narratives are told and conceptualised by “laying down routes into memory, for not only guiding the life narrative up to the present but directing it into the future” (Bruner, 2004:708). The approach therefore stipulates a means of conveying a sense of self through relating to others (Elliott, 2005) that is shaped through symbolic systems such as language that are produced from culture. Hence, meaning is created through the language we use to tell stories about our world. From this focus on human action we can already see an acknowledgement of self-agency and the potential for creativity in a way that other approaches previously explored (such as DA) do not.

To galvanise the reasons why Bruner’s (1991:6-18) method was considered the most appropriate for this study, it is perhaps important to examine the ten features that are believed to be core to his narrative approach:

1. ‘Narrative diachronicity’: the unfurling of events over time. Here, Bruner acknowledges Ricoeur’s (1984) difference between both ‘clock’ time and ‘human’ time, “whose significance is given by the meaning assigned to the events within its compass”. Time, for Bruner, is distinct from Labov’s description of time, which was mainly dependent on the sequence of clauses and hence “obscures an important aspect of narrative representation” (Bruner, 1991:6). This depiction of time can be seen to be highly relevant to the nature of humour and joke-telling, the temporal constraints foisted by terminal illness, and the fifty-minute psychotherapeutic session.
2. ‘Particularity’: the embeddedness of a story into a genre or the emblematic nature of its relevance to a more inclusive narrative type.

3. 'Intentional state entailment': the measure of agency in the narrative that is determined by the character's beliefs, desires, theories, values "and so on", and guides the way characters perceive situations as Bruner states: "agency presupposes choice – some element of 'freedom'" (1991:7). Here, he differentiates between 'causality' and the 'reason' for the subsequent action. Rather than providing causal explanations, narrative's role is to be the basis of interpreting why.
4. 'Hermeneutic composability': where the intended meaning of the text coincides with the reader's extracted meaning from the text, with the acknowledgement that what is expressed may be different from what is meant, and crucially that there is no one given meaning. To address the issue where there is neither a rational means of securing the 'truth' of the text, nor an empirical means of establishing the verifiability of the elements that constitute the text, Bruner (1991:8) claims that it is necessary to examine the interaction between interpreting the meaning of the text as a whole, and as a composition of individual components and their intended meanings: "A story can only be 'realised' when its parts and whole can, as it were, be made to live together". In referring to hermeneutic composability, Bruner also highlights 'intention', how and why the story is being told as well as how and why it is being interpreted, and 'background knowledge' of both storyteller and listener and their interpretations of the background knowledge of each other.
5. 'Canonicity and breach': Bruner (1990) posits that through interaction with each other, individuals create an appreciation of what is canonical against a background which gives meanings to deviations from the norm. The breaches, variations or deviations of normal occurrences or canonical scripts that are

involved in narratives, which according to Bruner (1991:9) who uses Jakobson's phrase, makes "the ordinary strange" and hence a story worth telling. Such breaches, he claims, can be linguistic as well as contained in the plot. The assumption here is that the story or expression will not end in the manner that it might be expected to when it started. As illustrated in Chapter 2, particularly in the discussion around the incongruity theory of humour, this is often how jokes are constructed too. Further, Bruner claimed that "such breaches are readily recognizable as familiar human plights" (1991:12), and terminal illness may be one such plight, as might be the therapist's experience of being with such clients in humorous encounters. Additionally, for Bruner (2001), narratives serve the function of entrenching us within our culture and we therefore tend to present ourselves as typical of the culture. A violation of the canon, or norm, then is done in a way that is coherent within our culture, through the culture's "narrative resources...its myths, its typology of human plights, but also its traditions for locating and resolving divergent narratives" (1990:68). This has important implications when considering current society's perceptions towards terminal illness and humour.

6. 'Referentiality': the requirement for the narrative to be identifiable with some reference to reality. Bruner (1991:13) states, "narrative 'truth' is judged by verisimilitude rather than verifiability". Narrative research involves a co-construction of a story between researcher and participant, where there is a teller of the tale and someone to whom the tale has been told. Due to this subjective experience of hearing, telling and re-telling stories that depends on narrator and audience, it is the reality of the speech in the plot and not the story's truth or falsity that governs the power of the narrative. Hence, the notions of reliability

and validity are less important. Bruner purports that rather than merely referring to reality, narrative allows for the creation and constitution for reality and that distinction between narrative fiction and narrative truth is questionable but can be answered through hermeneutic composability. Bruner also considers there to be no difference between factual and fictional narratives as they are situationally negotiated or arrived at through contingency. This has implications for research, and Czarniawska (2004:9) references Todorov to sum this up:

“...in this tacit contract between author and reader, the authors plead: suspend your disbelief, as I am going to please you. In what can be called a referential contract, the researcher pleads: activate your disbelief, as I am going to instruct you. It goes without saying that if the scientific author manages to please the reader as well, it is a bonus. In the meantime, the lack of structural differences between fictional and factual narratives is suspected to account for most of their power.”

As breaches in canons are socially sensitive, a story that is not built upon the difference between fact and fiction allows for one or many alternative meanings to emerge. As Bruner (1990:67) states, this “method of negotiating and renegotiating meanings by the mediation of narrative interpretation is one of the crowning achievements of human development in the ontogenetic, cultural and phylogenetic sense of that expression”.

7. ‘Genericness’: the telling of conventional human plights told through language in a particular way. Here he notes the importance of cultural context and posits, “to translate the ‘way of telling’ of a genre into another language or culture where it does not exist requires a fresh literary-linguistic invention” (1991:14), and: “while [genres] may be representations of social ontology, they are also invitations to a particular style of epistemology. As such, they may have quite as powerful an influence in shaping our modes of thoughts as they have in creating the realities that their plots depict” (1991:15).

8. 'Normativeness': the way in which the construction of the narrative breaches what is culturally considered as normal, and how this shapes the reader's interpretation and processing of the breach. When the breach is considered by the degree of its validation, it becomes 'Trouble', "and it is Trouble that provides the engine of drama" (Bruner, 1991:16). Bruner also states that the normativeness of a narrative changes as temporal and cultural contexts do, and is not dependent on how the Trouble is resolved. Indeed, "narrative...is designed to contain uncanniness rather than to resolve it. It does not have to come out on the 'right side.'...the 'consoling plot' is not the comfort of a happy ending but the comprehension of a plight that, by being made interpretable, becomes bearable" (1991:16). The strength of the story thus is not dependent on its bond to the world outside the story, but in its openness for negotiating meaning. What this narrative approach thrives on then, is the possibility of leaving open the nature of connection: "What is considered a vice in science – openness to competing interpretations – is a virtue in narrative" (Czarniawska, 2004:7).
9. 'Context sensitivity and negotiability': the negotiation of meaning between the presumption of what a text might mean, and what the reader potentially means it to mean. As Bruner (1991:17) states, "the notion of totally suspending disbelief is at best an idealization of the reader and, at worst, a distortion of what the process of narrative comprehension involves". The lens through which these are negotiated depends on background knowledge and cultural significance. This point addresses a number of the key aims of this chapter, particularly in wanting a method that acknowledged contextuality and relatedness.
10. 'Narrative accrual': the way in which the narrative is accumulated into a coherent whole, and also becomes part of the culture, history and tradition of other

narratives that become cultural references with which to understand the new narrative; an intricate dance illustrating how old stories become new stories: “What creates a culture, surely, must be a ‘local’ capacity for accruing stories of happenings of the past into some sort of diachronic structure that permits a continuity into the present” (Bruner, 1991:19-20).

Bruner’s method acknowledges an almost primitive sense of readiness for the narrative organisation of experience, where children are told stories over the course of their life which are “encouraged and elaborated in the course of life, exploiting the richness of the existing repertoire of stories and plots” (Czarniawska, 2004:9). Adults then enrich, challenge and continue the repertoire, and science too is a story of another story. This methodology chapter, for instance, is a story of how the method was chosen, based on stories that previous methodology books and articles were richly illustrated with.

Bruner’s approach to narrative can be encapsulated with this:

“Th[e] hermeneutic property marks narrative both in its construction and in its comprehension. For narratives do not exist, as it were, in some real world, waiting there patiently and eternally to be veridically mirrored in a text. The act of constructing a narrative, moreover, is considerably more than ‘selecting’ events either from real life, from memory, or from fantasy and then placing them in an appropriate order. The events themselves need to be constituted in light of the overall narrative – In Propp’s terms, to be made ‘functions’ of the story”

Bruner (1991:8)

What we have is a method that thrives on dialogue, flux and relatedness, in which truth is relative, intersubjective and contextual, and in which the researcher can stay open to exploration and possibility. Bruner’s narrative method appears to provide the balance between description and interpretation, as well as between the epoché and objectivity of interpretation of IPA and the over-subjectivity of heuristics: “narrative

requires something approximating a narrator's perspective: it cannot, in the jargon of narratology, be 'voiceless'" (Bruner, 1990:77). The cultural discourses in which individuals reside are acknowledged, but so is agency and creation – particularly in the creation of meaning. In returning to the three considerations for a suitable method – the capturing of a rich enough description of therapists' experiences; the allowance of societal and temporal context as well as for the relationship between humour and terminal illness, therapist and client, researcher and researched; and the ability to retain the vitality, spontaneity and playfulness of humour – Bruner's approach to narrative analysis fits best.

To finish with Czarniawska's (2004:10) statement, then:

"A student of social practices re-tells narratives of a given practice and constructs them herself, first and second hand. Nevertheless, she cannot stop here as, by doing that, she will be barely competing with the practitioners themselves, and from a disadvantaged position. She must go further and see how the narratives of practice unfold. This interest can lead her to a stance espousing the ideas of logico –scientific knowledge, as formalism and structuralism intended to do, or those closer to the poststructuralist edge of the spectrum of narratology."

It is with that in mind that Bruner's method has been chosen for the research question, 'how do psychological therapists experience humour in sessions with terminally ill clients?', to tell a story which may end tragically or comically.

4.7 Conclusion

The Literature Review raised what were thought to be three key considerations to be borne in mind when finding a suitable method: 1) the ability for the method to capture a rich enough description of therapists' experiences of humour in counselling terminally ill clients; 2) the ability of the method to allow for sociolinguistic and temporal contexts and the various relationships involved in the research question; 3) and the ability of the method to allow for the vitality, spontaneity and playfulness of humour.

Quantitative research methods were considered first for their elicitation of results that would be more generalisable and applicable to the psycho-oncology community as a whole, however they failed to address any of the three key considerations. Qualitative methods were thus deemed best, with IPA being considered a natural avenue to follow with its primary focus on experience. Its clear and solid methodological guidelines, which would allow for a sensitive and in-depth analysis, addressed the first concern. Secondly, IPA does not aim to speculate on the cause of experiences but to describe the experience as interpreted by the participant and researcher, which more or less addressed concern 2. However, its rigid structure – not only with conducting the research but also in extracting themes, was felt to jar with the way in which previous writers described the spontaneous, creative and playful nature which humour and language seems to inhabit and was therefore rejected as a suitable method.

Discourse analysis engages with power relations and has a sensitivity to language that was overlooked in IPA, which can highlight imbalances and subtle forms of oppression previously overlooked. This was ideal considering point 2, but the social-constructionist groundings of the method were not felt to be appropriate for point 1 or 3 as it does not allow for the personal meaning-making and contextual nature of humour, terminal illness, psychotherapy and research that a more phenomenological method might have space for.

To address these issues, heuristics was considered for its focus on subjectivity. This was particularly important given the researcher's personal experience of therapy, humour and terminal illness. However at the point of conducting the research, the researcher's personal involvement was not sufficient enough to meet the requirements of the method. Secondly, in being overly subjective, the method was thought to fail in

allowing for the relational aspects of the research question to emerge, as well as neglecting the cultural context in which the ‘self’ (either the researcher or participants) are experiencing. Where points 1 and 3 were sufficiently addressed by heuristics, point 2 was largely eschewed.

Narrative analysis then, particularly Bruner’s functional approach, seemed to fit best with the three considerations. The focus in this method is on the ways in which individuals construct and make sense of reality, as well as the ways in which meanings are created and shared. Consideration is given to how narratives serve to help individuals make sense of experiences, particularly through shaping random and chaotic events into a coherent narrative, making events easier to handle by giving them meaning. This last point is particularly well fitting with what was found in the literature review to be humour’s role in death. Bruner’s method is predicated on the view that the self is not a ‘thing’ but is storied and multi-storied, and the data that is generated is then also in the form of stories. Temporal unity is maintained through plot, for instance, which provides structure for how people make sense of their experiences. Further, the analysis is not so much about whether stories are true or not, but that narratives are social products that are produced by people in the context of specific social, historical and cultural locations. Bruner also claimed that a narrative’s function is to problem solve, allowing for the possibility of dealing with and explaining mismatches as well as for a full dialogue between speaker and hearer. Together, these aspects were felt to sufficiently preserve the complexity and temporal context of humour, death and the relationship between them both and the therapist, client, researcher and researched.

Chapter 5: Method

“A serious and good philosophical work could be written consisting entirely of jokes.”

- Wittgenstein (in Dribble, 2004:87).

5.1 Introduction

The purpose of this enquiry is to explore the experience of humour in psychological therapists working with clients diagnosed with a terminal illness. Rather than retain a focus on strategies of implementation and how humour should be utilised, or not, in therapeutic encounters, the primary interest in this research is to elicit information on therapists' lived experiences of the phenomena under consideration. Accordingly, and as discussed in Chapter 4, Bruner's (1991, 2004) narrative approach has been chosen. The aim of this chapter is to describe how data collection, participant recruitment, interviews and data analysis were conducted, with some consideration given to ethics, reliability, validity and replicability.

5.2 Data collection

In accordance to Bruner's (1991, 2004) narrative method, narrative interviews were chosen as the means to collect data. Narrative researchers primarily gather material for analysis through interviews, which allow participants to provide in-depth accounts of particular experiences. Chase (1995) and Murray (2003a) argue that in narrative interviews, the researcher's responsibility is to shift the responsibility of the interview back to the participant to allow them to shape and control the interview agenda. Standard in-depth interviewing can be said to be different to narrative interviewing in the questioning process and the responses elicited, where the former invites 'reports' and the latter invites 'stories'. In report-style responses, Chase (1995:5) contends that the burden of interpreting the significance of participants' responses rests with the researcher, "the one who asked for it in the first place". Murray (2003b) claims that

successful narrative interviews are those in which the participant feels the researcher values and is interested in their stories. This has been termed as ‘empathic attunement’ by Josselson and Lieblich (2001), in which the interview is experienced by the participant as an ‘encounter’ where the researcher accepts the story respectfully and without judgement or evaluation and is therefore grounded in the hermeneutic tradition as it “affords the possibility of interpreting others who themselves are engaged in the process of interpreting themselves” (Josselson & Lieblich, 2001:281).

There can be said to be two main types of narrative interview, the ‘life-story interview’, which aims to elude in-depth biological explorations of participants’ life experiences so far (Murray 2003b), and the ‘episodic interview’, which is more directed in eliciting participants’ everyday knowledge about a specific experience (Flick, 1997). The latter was felt to be more appropriate for the research question as the aim for this study is not to get participants’ life histories, but a deeper understanding of their specific experiences of humour.

Fundamental to narrative’s approach to collecting accounts is ‘reflexivity’ and the researcher’s role in co-creating narratives through the dialogic act of interviewing (Lieblich et al., 1998; Murray, 2003b). Mishler (1986) suggests that questions in the narrative interview can be thought of as circular processes through which their meanings and those of the answers are jointly and continually created through the mutual discourse of both researcher and participant. Consequently, researcher-participant bias is present from the beginning of the interview process, from stating the purpose of the interview through to asking questions and relating to responses, which according to Lieblich et al. (1998) and Flick (2002), ought to be acknowledged. To avoid the context of the narrative creating a false sense of coherence or emphasising the central role of the narrator to the neglect of others in the story,

interviewers are called by Gergen (1999) and Murray (2003b) to encourage participants to reflect upon the roles of others in their experiences, thereby articulating the relational and contextual constructions of their experiences.

5.2.1 Reliability, validity and generalisability

Qualitative research is often criticised for lacking reliability, validity and generalisability. Grounded in social constructionism and hermeneutics, qualitative approaches to epistemology adhere to the position that there is no fixed or knowable reality; and, the signification of experience is through words, which are open to a greater degree of interpretation than numbers (see McLeod, 2001). With specific reference to narrative research, Loh (2013:2) claims that it is

“vital for a narrative researcher to ask the following: How valid is this narrative approach? How valid is the analysis of the data? How valid and reliable is the collection of these ‘stories’, and how can a story be valid as an analysis? If the data is collected through the participants’ telling of their ‘storied experiences’, how do I know if they are being truthful? What if they made up a story or embellish the retelling? Will the research be valid then?”

To answer these questions and ensure that this study maintains empirical rigour, it is worthy to explore the four general guidelines that have been outlined by Yardley (2000), and reflected by Riessman (2002) and Lieblich et al. (1998) to assess the quality and validation of narrative analyses. First is ‘sensitivity to context’, which refers to the extent to which the phenomena under exploration is strongly grounded in the philosophical and intellectual tradition of the topic, allowing for a foundation upon which to explore the range of perspectives and therefore an analysis that is more profound and comprehensive.

‘Commitment and rigour’ focuses on the researcher’s prolonged engagement with the research topic and completeness in data collection and analyses, “not in

terms of size but in terms of its ability to supply all of the information needed for a comprehensive analysis” (Yardley, 2000:221).

‘Transparency and coherence’ is the third guideline, in which transparency refers to the adequacy of the contentions of the analysis providing a convincing version of reality, which also results in greater comprehension and insight for the reader (Lieblich et al., 1998). This is akin to Bruner’s statement that “narrative ‘truth’ is judged by its verisimilitude rather than its verifiability” (1991:13). The believability and trustworthiness of the narrative allows for deeper insight, empathy and understanding of the subjective world of the participant through the congruence that is felt by the reader resonating with the story. This is deepened by the coherence of the narrative, which Yardley (2000:222) describes as “the ‘fit’ between the research question and the philosophical perspective adopted, and the method of investigation and analysis undertaken” and can be evaluated by the relationship between the researcher’s interpretations with previous theories and research (Lieblich et al., 1998).

Lastly, ‘impact and importance’ concerns the ability of the research to become the basis for others’ work (Riessman, 2008). According to Yardley (2000) and Mishler (1986), qualitative studies that make the greatest impact are those that present a new and challenging way of understanding the topic, rather than being generalisable to the larger population as in quantitative methods. Eisner (1998) provides three ways in which a study can be measured for its utility: comprehension, where an otherwise enigmatic or confusing situation can be understood; anticipation, where descriptions and interpretations go beyond the information provided; and guide/map, which deepens and broadens experience by providing a direction the reader can consider.

For the purposes of this study, and in consideration of the above, Altheide and Johnson’s (2013:389) view was a guiding principle: that of the “ethical obligation to

make public [the researcher's] claims, to show the reader, audience or consumer why they should be trusted as faithful accounts of some phenomenon" and a "pragmatic utility of validity as 'good for our present intents and purposes'". As Loh (2013:11) states, "narrative research traditionally addresses the perspectives of both the researcher(s) and the researched; however, by not seriously addressing the issue of trustworthiness of its analysis and findings, it does not seem to be fully addressing the perspectives of its utility and audience."

With this in mind, the findings of the study are presented in a way that acknowledges the researcher's experience as informing the research, and thus as a range of possibilities rather than truths, which was felt to adhere to the epistemological aims of the study. In keeping with Bruner's (2004:702) assertions, the analysis of the data will retain an 'authorial voice' and employ direct extracts of the text to illustrate interpretations. The reliability of the study will hence be provided through making explicit the process in which the research was conducted, with the intention that, as Giorgi (1975:96) stated: "...a reader, adopting the same viewpoints as articulated by the researcher, can also see what the researcher saw, whether or not he agrees with it".

5.3 Participant recruitment and selection

5.3.1 Sample size

The number of participants chosen for this study was in accordance with the idiographic aim of qualitative research methods to provide a depth of understanding for new and challenging perspectives to emerge, rather than to extrapolate findings to a generalised population for an objective truth (Yardley, 2000; Charmaz, 2003; Smith et al., 2009). A purposive sample of six participants was felt to correspond with the epistemological and ontological aims of the study explored in Chapter 4. Further, six

participants ensured enough data for a range of information specific to participants to be collected without sacrificing the depth of the investigation to the number of participants, and without being so small that the phenomena are not sufficiently explored (Sandelowski, 1995). This was in keeping with Smith and Osborn's (2003:51) argument that a smaller sample size "should provide sufficient cases for the development of meaningful points of similarity and difference between participants, but not so many that one is in danger of being overwhelmed by the data generated".

5.3.2 Criteria for selection

The sample for this research was primarily purposive, in line with Polkinghorne's (2005:139) position that participants "are not selected because they fulfil the representative requirements of statistical inference but because they can provide substantial contributions to filling out the structure and character of the experience under investigation". The initial criteria for selection were therefore that: a) participants were psychological therapists with experience of working with clients with terminal illness; b) participants would have access to support from professional colleagues, supervisors and/or personal therapists for any issues arising from the interview process; and, c) participants were members of the BPS, BACP or registered with UKCP. At the point of recruiting participants however, it was felt unnecessary to ask that participants were accredited or registered with a professional body as this might have placed too much of a restriction on the selection to no great purpose. With many experienced practitioners yet to become accredited or registered, and some choosing not to be, it was considered that students – as long as they were psychological therapists with experience of counselling terminally ill clients – fitted the criteria. Whilst it was considered that the interview topic would result in minimal

distress, this last point gave import to ensuring the criterion regarding support from colleagues, supervisors and/or therapists was met.

5.3.3 Recruitment

Recruitment for participants only began when ethical approval was granted (see Appendix 1). Services that were local to the researcher and offered counselling to terminally ill clients, which included hospices and out patient services, were emailed with an invitation letter (see Appendix 2), which included an introduction to the research and contact details of the researcher. For purposes of confidentiality and given the sparseness of such services, the locations of these services will not be identified here. Directories such as Counselling Directory and the British Association for Counselling and Psychotherapy (BACP)'s Find a Therapist were searched for counsellors that claimed to have experience of working with clients diagnosed with terminal illnesses and had their email addresses available to the public. Those who indicated that they wished to be excluded from canvassing were not contacted. Some recruitment 'snowballed' with one participant/service recommending another. Interviews with the first six suitable respondents were scheduled either via email or telephone at an appropriate and convenient time and location for the participant.

Although participants were largely self-selected, which therefore eliminated researcher bias, they could not be described as a random sample since they clearly had some reason for volunteering for interview, whether altruism, curiosity, or a sense of something to contribute to the discussion. They were nevertheless a diverse group with regard to the level of training and experience, theoretical orientation and client base, which was considered by the researcher to be beneficial, bringing a variety of experience to the enquiry. A further benefit of this research was that participants were being given an opportunity to take part in a project that would potentially allow them

to reflect upon their practice, which for many was an important aspect of on-going continuing professional development. With particular reference to narrative analysis, a task of the research is to make sense of the meanings and understandings individuals attach to their experiences and when working with dying patients, and particularly discussing humour which many had not had the opportunity to do in a formal setting, this was possibly an invaluable opportunity to explore and understand these aspects of therapeutic practice.

5.3.4 Participants selected

All the participants were employed in palliative care settings, and aged between early forties and early sixties. Two were female and four were male, with theoretical backgrounds based mainly on humanistic principles. Five of the participants were counsellors and one was a clinical psychologist. All six were qualified psychological therapists and had registration with professional bodies.

5.3.5 Ethical considerations

A risk assessment (see Appendix 3) was carried out and approved before interviews commenced. Prior to interviews starting, participants were given the consent form to sign and return (see Appendix 4). All six interviews took place at participants' places of work and the local guidelines and regulations in regard to the University's Lone Worker Policy, and any health and safety procedures when working offsite were identified and followed. Participants were informed that their interview data would be used as part of a thesis, some of which could be subsequently published. Therefore each participant was assigned a pseudonym and any information that referred to recognisable people or places was changed or removed to preserve confidentiality and anonymity. Participants were informed verbally and in writing that they could withdraw from the research at any point prior to submission, which was expected to

be in September 2015, without giving reason. They were also informed that if they withdrew before the end of December 2014, at which point the data would be analysed and form part of the PsychD thesis, it would only be used in collated form. Further, in accordance with the University's Code of Good Research Practice, data would be retained for up to ten years from publication. All participants consented and none subsequently withdrew. As all participants had experience of working with terminally ill clients and were in regular supervision, it was assumed that personal distress due to the subject matter would be minimal; however attempts were made to conduct interviews with ethical attunement (Brinkmann & Kvale, 2008).

5.4 Interview procedure

Each participant was interviewed once and interviews lasted between forty and ninety minutes, and in accordance with Bruner (1990) were relatively informal with no pre-set questions, other than an opening statement inviting participants to recount their experiences of humour in sessions with terminally ill clients. In keeping with Murray's (2003a) description of an active listening process, the researcher closely reflected on participants' stories and offered minimal interventions, which were aimed at either opening up a topic for further discussion, clarification, or maintaining focus, though the latter was not often necessary. This provided both participants and researcher with the opportunity for greater reflection on and deeper understanding of the particular experience.

The participants were also asked to present a joke or quip related to the phenomena with which to potentially introduce their narrative during the presentation of findings in the thesis. All six participants said they would get back to the researcher, yet none of them did. This was a noteworthy observation as it harkens back to the common understanding explored in Chapter 3 of humour being

spontaneous and impulsive. The idea of presenting a joke, therefore, potentially seemed contrived.

Interviews were audio-recorded on two recorders to minimise technological failures, and conducted under conditions of uninterrupted privacy. The audio recordings were deleted from devices once they were uploaded onto a computer and backed up on a USB stick, both of which were password-protected and accessible only by the researcher. The subsequent transcriptions were stored in the same way. Interviews were heard only by the researcher, who was also the only one to transcribe in order to develop data familiarity and improve interviewing skills concurrently, as suggested by Saldaña (2013). The process of transcribing was therefore reflexive and “require[d] the transcriber’s cognizance of his or her own role in the creation of the text and the ideological implications of the resultant product” (Bucholtz, 2000:1440). A transcript in its entirety (with identifiable information changed or blacked out) can be seen in Appendix 5.

During transcribing, attention was paid to silences as well as the words used and instances in which the participants and researcher laughed, as this was felt to be poignant to the study, as will be discussed further in Chapter 8. The grammatical structure of participants’ speech was also preserved in transcription, as this was felt to indicate the interrelationship between structure and content.

5.5 Findings and analysis

With no clear guidelines and very few published articles on how to present the findings on research conducted using Bruner’s narrative research, the researcher felt that she was in a position to be relatively creative with how participants’ accounts were portrayed to the reader, so long as the ethos of Bruner’s narrative theory was adhered to. It was also while considering the transcripts that the researcher was

intrigued by what humour and death, were they to be characters in a story, would think of this piece of work, and in developing that thought it felt almost impossible not to include them in the story as part of a narrative framework.

In considering presenting the findings and subsequent analysis, narrative can be employed as a means of telling a story in order to convey meaning and render a difficult experience safe; the functions of narrative include reducing tension, finding solutions to problems and resolving dilemmas (Bruner, 1990) and so the researcher feels this is an appropriate method for allowing participants to explore their experiences of working with terminally ill clients.

Following the interview and transcription, the stages for conducting the analysis in accordance with Bruner (2004) start with organising data by reading each transcript with the research question in mind, making notes in a column with reference to line numbers. Stories will then be created with a plot, scenes, characters, beginning and ending, with direct references to the transcript as required. These stories will then be analysed with regards to Aristotle's (trans. 2003) depiction of the structure of Greek theatre discussed in Chapter 3. The reason for this is to afford the analysis of plot with a structure that does not appear to have been conducted in any other narrative research, and is particularly poignant here given the argument that comedy is a response to the tragic.

The identification of similarities and differences of themes present in these narratives will be identified, as will breaches of these themes, as "a tale must be about how an implicit canonical script has been breached, violated, or deviated from in a manner to do violence to ... the 'legitimacy' of the canonical script" (Bruner 1991:11). These stages will be conducted before the final story will be written up in Chapter 6.

The language used by participants, and how it is used, will also be explored in order to identify the meanings created through their construction of themselves with the intention to provide a holistic dimension to the analysis. By doing so, the story will be taken as a whole, with sections being interpreted in the context of other parts of the narrative, and will allow for the development of multi-layered interpretations (Camic et al., 2003).

Overall, data will be interpreted by looking for patterns, themes and regularities as well as contrasts, paradoxes and irregularities, and narrative forms will be created by constructing a coherent story from the data and by looking at the data from the perspective of the research question. In doing so, participants' experiences of humour in their work with terminally ill clients, as well as the meanings created in their conceptualisation of this work, will hopefully be effectively conveyed.

Chapter 6: Results

“Stories are a parasitical life form, warping lives in the service only of the story itself.”

- Pratchett (1991:14)

6.1 Introduction

This chapter presents the findings, following a thorough reading and re-reading of interview transcripts. It was during this period that the researcher was struck by how the participants spoke about the phenomena of enquiry and wondered how humour and death, were they to be characters in a story, would consider what was being said. In mirroring what was found in the literature review with regards to the changing attitudes towards both death and humour through time, and in homage to the notions of comedy and tragedy arising from theatre that have been discussed earlier and could be said to be a foundation of this thesis, the decision was made to portray participants' narratives as a play. Van Maanen's (1988:19) thoughts were also felt to be appropriate here: "little need was felt to do much more than gather and arrange the materials, for they would...speak for themselves", however one full interview is provided in Appendix 6 to maintain Giorgi's (1975) contention that the point of qualitative research is not that readers agree with the findings, for it is a given that they may not, but they should be able to see clearly how the conclusions were reached.

6.2 Findings

Characters

DEATH: Death

HUMOUR: Humour

THERAPIST: Any one of us

HELEN: Has worked in terminal care for 25 years, initially as an auxiliary nurse before training as a counsellor, with practice hours at a GP surgery. Has been a counsellor for a palliative care setting for 7 years.

HERMAN: 'got involved in lots of different areas around HIV, around private practice and all sorts of things' and has been working as a counsellor for carers and relatives in a hospice for 5 years, with the last 2 of these including terminally ill patients.

TED: Chose to begin counselling training after a redundancy from a background that 'has got absolutely nothing to do with counselling and palliative care'. Started volunteering in a hospice, which led to employment as a counsellor and supervisor.

CAM: A patient and family therapist at a hospice for 2 years, working with patients in the community and on the ward where they are admitted for symptom control, respite or end of life. Describes himself as an integrative practitioner, matching interventions to presenting issues and personalities of the patient.

PENNY: Has been working at a hospice for 10 years in 'a mixed role', managing a team and seeing patients, relatives and children.

RUPERT: A clinical psychologist with a history of working in adult mental health, before being asked to specialise in terminal care, which he has been doing in hospices and palliative care centres since the 1990s as a counsellor, trainer and supervisor.

RESEARCHER: A doctoral student and counsellor in a palliative care setting and hospice for nearly 2 years.

Scene 1: 'What brings you to my door?'

[DEATH, HUMOUR and THERAPIST are stage left. Stage right is in darkness. DEATH and HUMOUR enter a therapist's office and sit down a distance from each other. There is clearly some tension between the two.]

THERAPIST: Thank you both for coming today. From the telephone conversation we had, you told me that you're having some problems in your relationship. Perhaps you can tell me what brings you to my door?

HUMOUR + DEATH: Well the problem starts...

THERAPIST: It would be helpful if you could speak one at a time and not interrupt each other.

HUMOUR: [To DEATH] Seeing as you always get the last word, perhaps I should start?

DEATH: [Rolls his eyes] There you go again.

HUMOUR: What do you mean?

DEATH: You always try to diminish me.

HUMOUR: You diminish everything!

DEATH: Can't you take this seriously, just for a minute?

HUMOUR: Jeez, sorry for trying to lighten the mood. [To THERAPIST] He can be such a moody so and so sometimes. No fun at all.

DEATH: [Defensively] Actually, I can be funny.

HUMOUR: Really?

DEATH: Yes. I have a joke. Ahem. Death walks into a bar. He orders a pint of beer.

[HUMOUR + THERAPIST look at each other perplexed]

HUMOUR: And?

DEATH: Death was thirsty.

HUMOUR: ...and did Death order a bucket and a mop?

DEATH: No.

THERAPIST: I think we might be veering off subject. What brought you both here today?

DEATH: I'm having one of those mid-life things...you know, an...existential crisis? I get some pretty bad press, and frankly, I don't think [looks at HUMOUR] she helps.

HUMOUR: I'd ask if you're joking, but I know you're not. I can't believe you're blaming this on me. [To THERAPIST] Do you know how hard it is to be funny when he's near me?

THERAPIST: What makes you think it's hard to be funny around him?

HUMOUR: The two of us are hardly a natural couple. It takes a lot of work to make us work.

DEATH: I do not make it hard work. I simply am.

HUMOUR: You are so passive.

DEATH: I cannot help it if people come to me naturally. How do you think I feel? I know you don't want me around when you're doing what you do. It is not as if I make it hard to be funny.

HUMOUR: But you do make it so hard for me. I'm only trying to make people feel better.

THERAPIST: Can either of you give me an example?

DEATH: Very well...

Scene 2: 'A personal experience of humour'

[Lights up stage right. HERMAN, TED and CAM sit opposite RESEARCHER. DEATH, HUMOUR and THERAPIST watch the scene but HERMAN, TED and CAM and RESEARCHER are unaware they're there]

HERMAN: That whole thing of death and humour, you know, black humour and all the rest of it...it can be uncomfortable for a lot of people and culturally it can be very difficult as well...

(HERMAN pauses).

HUMOUR: See? Straight off the bat; he feels uncomfortable about me!

DEATH: You of all people should know to wait for the end and the punch line.

HUMOUR: That's rich coming from you.

DEATH: Just listen, will you.

HERMAN: I passed my personal boundary and have laughed in loads of situations that are very black such as at funerals...I've had bereavement in my family, and humour was an everyday part of what we did and actually it helped cope, it was normalising...But my personal experience of humour doesn't translate quite so easily when you're with a client. The prior is fine because that was about me, but with clients, it's constantly being aware of those boundaries and trying to hold them.

TED: My sense of humour was important when I started working here...what I did have was my personality...I always like to bring a bit of fun, a bit of humour into things because I think, well, life is funny...life's too short, you know, make fun of things, enjoy it, see the funny side. Like Life of Brian's, 'always look on the bright side of life' [Laughs]

DEATH: [Sarcastically] Or even, 'always look on the bright side of death'

RESEARCHER: [Laughs]

CAM: When my mother died, we found a letter that she'd left, 'instructions for mum's funeral'. There were all sorts of things on the list, 'these are the song's I'd like', and in brackets, 'not that version because I always hated that one', and there was humour there, so humour from beyond the grave.

[Lights down stage right - DEATH, HUMOUR and THERAPIST resume.]

DEATH: See? I remember the good old days when...[gets lost in reminiscence]

THERAPIST: You said earlier you're feeling diminished. What's that like for you?

DEATH: [Ignoring THERAPIST] I remember the good old days when I was taken seriously, there was none of this [looks at HUMOUR] *joking* about me.

HUMOUR: And don't I just know it. You've made it very clear that I shouldn't make jokes about you.

THERAPIST: Perhaps you can give me an example of what you mean?

Scene 3: 'Capital S Serious'

[Lights up stage right - HERMAN, TED and CAM, who sit opposite RESEARCHER.]

HERMAN: There's a preconception that we have about humour being taboo. When people are dying, you can't be humorous...I think there's something about this profession that we have, and all the training can sometimes give us this sense of having to present this certain face, but it's not about putting on the mask and being the therapist, it's about being Herman!

HUMOUR: See, I'm a taboo!

DEATH: Actually, I think you'll find I am...

TED: There can be an element of 'I have to be deadly serious here'...the situation that patients or families find themselves in is not a laughing matter, it's not what the humour's around but I do think sometimes counsellors don't demonstrate something which is quite a human side of working with another human being...I think generally speaking in the public, certainly in this culture in this country, we don't talk about death...most people in the community don't deal with people that are dying, they can't imagine where humour perhaps would come into it...they don't want to say anything wrong and upset them so therefore 'I won't say anything, I'll stay away'.

CAM: I really ramped it up before I started working here. I thought the work was, you know, capital S Serious...I remember when I had my interview, I showed no humour in it whatsoever, I was so...clinical and existentialist and Freudian...But it was on my first day here that I noticed the warmth in the building and the camaraderie and laughter...At first, I thought 'oh god, that's insensitive', but I very quickly realised that all the work is serious, I'd just made

the presumption that this is über serious because it's about death, but you can't maintain that...you have to temper it with humour.

[Lights down stage right. DEATH, HUMOUR and THERAPIST resume.]

HUMOUR: I can see that people like me being around, but I can't help but feel they aren't sure when it's ok for me to be there.

THERAPIST: What might you mean by that?

Scene 4: Being guarded with the first client

[Lights up stage right - HERMAN, TED and CAM, who sit opposite RESEARCHER.]

HERMAN: I felt the need to be guarded with my first terminal client, not saying anything that might be offensive or make light of the person's situation, and so being humorous felt uncomfortable. The presence of humour somehow undermined the seriousness of what they were going through. I got very anal with that first client, wrapped up in the devastating situation that client was in, you know, with their life passing by...I think my resistance in those early days were more based around my fear, not really around the client's fear because he was clearly attempting to communicate something in a different way, and trying for it to be allowable and old me said 'no' [Laughs] in a very subtle way just by not responding to him, thinking 'what the hell do I say?' It happened three times and bless him, he kept trying...I wanted to laugh because it was humorous and I felt guilty for wanting to laugh.

RESEARCHER: How did it leave you feeling?

HERMAN: Well, I just kept a blank canvas and felt very uncomfortable knowing that I'd missed something that could have been really embracing and holding...and recognising that perhaps it disallowed them from engaging with their own state, their own way of being because I felt so closed off. But having worked through this with the first client, with the other clients, it almost became an expectation...that humour could be there, you know, in that way.

CAM: I don't think I'd have dared using humour straight away here, but as I've learned, there needs to be a light touch to it.

PENNY: I don't think humour's always been there. I think I've got better as I've become more experienced. I'm pretty sure that in the early days, I would have allowed myself to be distracted by it, so a funny story or whatever, I would have listened to it and it would have taken up ten minutes of the session, but now I might allow that once or twice but I think I've got better at it over the years.

[Lights down stage right. DEATH, HUMOUR and THERAPIST resume.]

HUMOUR: They resist me. You make them *resist* me.

DEATH: That's only when they started working there. You're only choosing to look at the bits you want to look at.

HUMOUR: Am I?

DEATH: Yes. Besides, do you think it is appropriate for you to be there all the time? Are some things not deserving of seriousness?

HUMOUR: I see your point. It is simply that...I don't like to be discarded because people don't think they should use me. I might even be helpful. It hurts to be cut out.
THERAPIST: How might that be?

Scene 5: 'Humour in the early days'

[Lights up stage right - HERMAN, HELEN, RUPERT and CAM, who sit opposite RESEARCHER.]

HELEN: Humour's not really there at first...because you're only gauging where you're at with them and where they are...you have to be more cautious...I certainly wouldn't be wanting to use something that I thought was funny or would help when that wasn't where they were coming from with that.

RUPERT: I think after that initial putting someone at ease, and the next session, I will assume that I don't need to do quite so much of the putting at ease, sometimes you do but often you don't so I'm much more going to follow their lead in terms of how we start off.

HERMAN: Humour in the early days can be quite challenging because you don't really get the other person just yet. Once the trust and understanding has been established, then it works really well. With clients who are terminally ill, they use humour much earlier...It comes in the very first session sometimes and they make some sort of glib comment and I know they're waiting for a reaction...Quite often in the early stages of your engagement with therapy, there's a distancing that happens, and it's about testing the waters as well, it's 'I can joke about this and you can accept that and if you can joke about it and I can accept that then maybe there's something we can do that's, you know, positive here'.

DEATH: Cam sums it up well...

CAM: It doesn't happen straight away. Sometimes it does.

[Lights down stage right. DEATH, HUMOUR and THERAPIST resume.]

THERAPIST: I think we've made some good progress [Looks at DEATH] and I'm wondering how you feel about what's been said?

DEATH: I'm as much a part of life as anything, yet people feel the need to joke to make me more acceptable.

HUMOUR: Knock, knock.

THERAPIST: Who's there?

HUMOUR: Death! [Laughs]

DEATH: [Sulks]

THERAPIST: I can see you're not happy with that, what does it mean to you?

DEATH: I'm jealous that people would rather have Humour around than me.

Scene 6: 'Working with the terminal'

[Lights up stage right - HERMAN, HELEN, RUPERT, TED and CAM, who sit opposite RESEARCHER.]

HELEN: I think having something so, you know, life-limiting, from diagnosis, whether it be the patient, carer, relative, from diagnosis everyone's world has been flipped. It's a change that has to happen, even just to adapt to the news...and I think that's the real leveller. That's when you get real bare bone, that's almost the worst situation that could happen.

HERMAN: Working with the terminal, you see how people actually live with their illness, with the fact that they are dying and that acceptance and understanding...We're looking to improve the client's understanding of himself, their ability to live with themselves, make the appropriate decisions for themselves and afford a better quality of life that they can embrace much more wholly. It's not like that with terminal clients...For me, it's about how to allow them to reach an end that they feel happy with...You're not trying to make it better because you bloody well can't. Client's gonna die. They know they're gonna die... and I can't make it better. I can't even pretend that we can try and quote unquote fix... The difficulty for me is the lack of hope you have in terms of being able to go on and lead a full life, because that always comes from our own reference point. A full life for me is another 10, 20, 30, 40 years...that isn't the way for the client...for me, it's about allowing them to be how they need to be...so that they get a sense of something, what that something is I can't tell you...But there's part of those people gets lost, that's how it feels...You lose the vitality and you lose the ability to be humorous.

TED: You know, there's deathly sad, sad, desperately sad, all the various emotions and things that go with the circumstances they find themselves...Some of the circumstances are so different to what they ever anticipated when they got married, when they had children, when they did whatever they did, and suddenly they find their partner or whatever is dying of a life-limiting illness, it throws up a different type of life they never knew even existed.

CAM: For these clients, death is knocking at the door every night. And you get those that are pragmatic or clinical in their presentation and they're holding something back and therefore keeping you as a therapist away. That's not to say that it's a permanent position, but it's worrying because that's when existential anxieties can happen and with the families the complex grieving can happen because the work that can be done now sometimes isn't allowed.

RUPERT: I'm always very careful because the clients I work with are often highly distressed...by definition, that's why they're going to see you or I. You see these people going through quite significant mood swings, so even though physically the situation may be the same or deteriorating, we may still find that from session to session they've changed from being quite low to quite high, and certainly within sessions as well.

[Lights down stage right. DEATH, HUMOUR and THERAPIST resume.]

DEATH: I understand their fear. It would be nice if people didn't hate me for being who I am. I can't help that.

HUMOUR: Then why be upset with me? I only try and help people see you in a different light.

DEATH: But sometimes when you do, you can make it much worse if you're not careful.

HUMOUR: Sure, go ahead. Criticise me. Everyone else does.

THERAPIST: What makes you feel as though people criticise you?

Scene 7: 'Humour's actually risky'

[Lights up stage right - HELEN, HERMAN, TED, RUPERT, PENNY and CAM, who sit opposite RESEARCHER.]

HELEN: If someone was completely struggling with complex grief and they were telling you something, you certainly wouldn't come back with a quip that was meant to be humorous.

HERMAN: Some clients use humour to distance...I think certainly in British culture, there's something about humour being often annihilating for some people...and that can be uncomfortable in therapeutic sessions, because if you come in with that sort of remit...how can you do something that's possibly insulting?...It's like this one client: whilst I was just making an aside comment as a way of reflecting back how we could look at this in different ways...she took it very much as a major insult that what she was feeling wasn't right, and that's where that belittling sense comes in I think. She did lighten up after a while but it took two or three sessions to actually get over the rupture, but it also allowed her to reflect on where she was at and what she wasn't doing or allowing herself to do, i.e. humour. I guess that's an argument for saying maybe its right but, I don't know, it's a hard judgement call.

TED: It makes me think of this client I recently saw where there was no humour at all...and I wouldn't have brought any in because she was in the depths of despair and there was no place for it...But at the same time, there are some counsellors that can be too counsellory and not human enough.

CAM: Sometimes laughter and humour mask pain...I wonder sometimes whether it can be smoke and mirrors. As a therapist, I have to sense the incongruence of it...it's just about listening first of all that you can hear, can't you sometimes, if a laugh is not natural, if it's almost like, 'no, everything's fine'...and that can make me feel really uncomfortable because immediately I'm thinking... 'you're really, you've got a lid on your pain'.

PENNY: I don't use humour as a way of wanting to be buddies, because it isn't that, or that I use humour as a way of lightening the mood because actually it was too heavy to hold, I don't mean that either. Humour's actually risky because the message isn't...lets laugh about it because that's a way of avoiding it, or we'll laugh about it because it's better than crying. The laugh isn't humorous, the laugh is, 'I'm going to laugh because actually I want to cry', or 'I'm going to laugh because maybe I don't really know what's going on but I'm overwhelmed by something and I don't know how to behave in this moment so I'll laugh'. That can be quite distracting to the therapist.

RUPERT: There are times you are really needing to sit on somebody because they may be making too light of things, using it too much as a protection or perhaps distracting...obstructing progress...There's a danger with more elaborate humour, in that to some extent you will start to worry whether the session has been started to engineer around it [laughs] you almost set your patient up so that you can tell a particular story in a certain way....I do hope that clients don't feel an obligation to make me feel more comfortable, but you get that, don't you, clients that take a lot of responsibility for the emotion that's in the room and the concern not to say things that upset or burden...that sense of responsibility they

have to look after everybody else as well as themselves....I do have a cautionary note too, in fact. I think humour's fine at the beginning - if you've misjudged it, you've got plenty of time to sort that out, but humour at the end of the session is potentially quite dangerous because you're not getting the opportunity to fully judge the impact...and also because you're relaxing too much yourself at that point, you're more likely to misjudge it..

[Lights down stage right. DEATH, HUMOUR and THERAPIST resume.]

[DEATH and HUMOUR sit in a sullen silence.]

THERAPIST: It seems like that has stirred something up for the both of you. How are you feeling?

HUMOUR: Sad.

[Pause]

DEATH: [To HUMOUR] Don't be too sad. It's not all bad.

HUMOUR: [Looks at DEATH in a surprised way] Really?

DEATH: Of course. Where would people be without you?

HUMOUR: What do you mean?

DEATH: Well for Helen, for example – she says you help make a bond with clients, and that you diffuse heavy sessions...

HUMOUR: How do you know that is what Helen said?

DEATH: One of the perks of the job.

Scene 8: 'Humour helps treat the client like a person, not like a dying person'

[Lights up stage right - HELEN, HERMAN, TED, CAM, PENNY and RUPERT, who sit opposite RESEARCHER.]

HELEN: Like this one client who had this whole series of misfortunate events [Helen goes on to list what happened] [laughs]

RESEARCHER: [Laughs]

HELEN: [Laughs] So as you've just laughed there, that was the nature of the session. I was laughing with her, I was empathising with 'oh dear,' you know, 'oh gosh', 'well, you wouldn't have known'...Using the humour with it softened her embarrassment...and my laughter was with her not at her....But humour also breaks the ice. I think if you were visiting somebody that was dying, that literally only had a few days or what have you to live...if they instigate humour, I'm not sure...whether they do that to break the intensity, or whether because sometimes we can, it's like taking pot shots at yourself, people that make humour about their own situation...often that is to relieve tension.

HERMAN: For some, I think it's a really good observation on life...a point where they say...'I can say whatever I like because I've earned the right to do it'...Humour helps treat the client like a person, not like a dying person. Actually for me, humour goes past the situation and touches the person...It feels more genuine, I can be me. And that also I think helps the client to be them...Humour is also a liberation, it actually feels quite refreshing...I feel liberated as well, to be able to experience that with [clients] but I felt more that it [is] about the client being able to liberate herself from the distress and chains of expectation...My clients,

they're allowed to laugh, and can maintain the vitality, and I know that's a really strange word to use in terms of death, but it is a vitality. Just because I have this, why does it mean I have to die before my time? And not die. And not die. And not die prematurely. Not die in their personality and their way of being. Humour means my client can be more than a shell of expectation that people place upon them, or even that they place on themselves.

TED: We need to be inclusive of all of that the client brings, excluding humour would be a bit like excluding conversation or excluding facial expressions, it is part of us, isn't it? The therapeutic relationship is important to me and it's about a relationship and that relationship can reflect the relationship with others in the community...and life has humour in it so why would you come into the room with another human being and it be excluded? Why would you?...Humour makes the sessions a bit more enjoyable and it also deepens the relationship and shows a level of trust...by showing that they're seeing the funny side of something that's to all intents and purposes a very, very serious situation, they are maybe feeling a level of trust with what's in the room for them to be able to joke about it...By sharing in that humour, you're acknowledging where they are in that situation, where clients can recognise the absurdities of their lives...They can laugh about it, and laughing with them, it's a laughing together...it's like an acknowledgement...it's potentially just acknowledgement of another feeling.

CAM: All the patients have something in common, which is that they're at the end of their life and we don't have time sometimes to work out how to pitch the work, so it's a bit of a gift when humour is used by the patient...it feels like they're giving you a bit of an invite, ok this is how I can work...At the end of life, people are laughing at what it means to be human. Most of my patients aren't afraid to die but rather want more of this. Life. And normally it's because they've enjoyed it and it's been fun. They don't want more misery but they want more fun...And it's alright in these sessions to smile with them, to laugh with them, because that type of reminiscence can be really, really therapeutically powerful for them...in remembering, they can depart from their current experience for a while...It's like they're saying 'remind me what being well is like.' And if we treat people as they are, we make them worse. If we treat people as they ought to be, we help them to become what they are capable of becoming. And that's the thing, don't treat them as they are, miserable, treat them as they ought to be treated, as that full, holistic, yeah...When clients wrap what they're feeling in a bit of humour, they're actually being kinder to me as a therapist...And the other thing is, humour makes therapy more open. It almost moves quicker, which is more important when working in end of life care because the sands of time tend to be running quicker. Again, it's about permission, 'ok, I'm letting you in. I've opened the gate, you can come in'.

RESEARCHER: An invitation, almost

CAM: I'm going to let you in, come and sit next to me. Let's have a talk but let's have a laugh as well...One client was pushing buttons all the time via a sense of humour, really pushing the boundaries, um almost like a teenager so I wondered whether the sense of humour reminds the person of how they used to be, makes them feel a bit young again, when I was cheeky...it is playful...Now when this patient died, I was more affected than I would be had the relationship been purely clinical. I was really upset because I really enjoyed her. She made me laugh. And um because of the sense of humour, I really respected her as well. I admired her. In the face of death, humour's a way of keeping your dignity...It's

being at ease with it...I'd go on record as saying that those who congruently use humour in their sessions are going to have a good death because they had a good life.

RESEARCHER: A good death?

CAM: A lot of the patients who have a sense of humour, I do imagine them dying with a smile on their face. Those who use humour more in their sessions it feels to me as though they've had a happier life and therefore they may have an easier death, or be more at ease with it...When humour happens, it's quite astounding. It really astounds me sometimes. I think it's quite brilliant. It's like that quote, 'whilst the fighting spirit cannot cure, it can prolong life' and I feel that the fighting spirit is, well humour is needed in it.

PENNY: I end up curious really sometimes about what clients are telling you in the humour because you can get some quite useful information by actually what they say...But it isn't about let's make a joke of this its more about it's a way of making contact with people, isn't it? And particularly when you can feel there's a tension and I'm wanting to put across that actually I'm just a normal human being. So I think I do use it as a way of trying to um help someone relax or as a way of making connection. I think I only use it as a way of getting on someone's wavelength. And building a relationship, because they have to connect to me as a person and I think that's how I would use it. And actually those people that use humour are easier to work with

RESEARCHER: I wonder if you can say a bit more about that?

PENNY: It's almost as though humour just gives a bit of respite in the conversation...and it kind of just for a moment you can take a breath...And it's not just despair. Because there are some that are just despair and you come out feeling completely drained.

RUPERT: I will always try with people to put them at their ease by being as friendly and relaxed as I possibly can, therefore little bits of humour about the situation we find ourselves at this point, something that might raise a smile or whatever might just help with that rapport building, it is essentially about establishing that engagement, that rapport um so whatever does that...it's self soothing isn't it, so they relax themselves, like I do when teaching, it's me I'm putting at ease with a little bit of humour with my audience and I think similarly quite a lot of our patients will use a little bit of light hearted banter of some sort or another to put themselves at ease in my company

RESEARCHER: Does it feel as though you're putting yourself at ease when you use it with clients?

RUPERT: Well obviously some patients, you feed off their anxiety, so um so yeah it probably is actually, it's about settling myself in as much as, yeah you're quite right...But of course because on the whole it does tend to be at the level of the in the moment banter, um rather than anything more than that, then a lot of it just comes and goes...Like in a group I ran...they were saying important things, but they were also using humour as a way in which they could actually cope with saying it I think. It was really, it was soothing them at the time, it was stopping them from feeling overwhelmed by emotion...there was a sense of coming together and exploring how they adjusted to this new situation, this set of circumstances, how it made them feel about themselves, how it impacted upon their relationships with others...If there's some laughter in the room, um then to me it feels like it's balancing the session. Like the idea that within a particular session with somebody whose distressed, if as well as them being

able to cry it's also possible for them to laugh, then I really feel like we've covered the range and it's saying something quite positive about our relationship that it can actually have both of those in it um and its also something about the emotional flexibility of the individual, that they've been able to make that sort of switching around within a session, because that's what we do normally after all. And there have been a number of occasions where people have said to me, 'that's the first time I've been able to laugh in weeks' or whatever and I've really liked it when people have said that.

[Lights down stage right. DEATH, HUMOUR and THERAPIST resume.]

THERAPIST: That is the first time in this session that you've supported each other and I'm keen to explore how you can both keep going with it.

HUMOUR: I'm happy to try. I want this relationship to work.

DEATH: Me too.

THERAPIST: That's a start.

HUMOUR: Perhaps I'm too fixated on looking at one issue?

DEATH: I think we both are.

THERAPIST: So how do we get past that?

Scene 9: 'I don't think it's necessarily unique to this setting'

[Lights up stage right - HERMAN, HELEN, RUPERT, TED, PENNY and CAM, who sit opposite RESEARCHER.]

HELEN: In my general nursing, I don't think humour really played a part. My work at the hospice, I don't know if it's something different where if someone is terminal or has a life-limiting or life-changing illness or situation, that whether that in itself makes a meeting of minds. I don't know if humour's more there, but it's different...

RESEARCHER: What about in the general practice you did?

HELEN: Probably less, I think. It was probably slightly different because I see people at home as well so I think you're a bit more relaxed in that sort of environment um, a GP surgery I worked in, I think humour didn't really enter any of those, it was a more formal sort of structure.

RESEARCHER: So it felt more structured in private practice, or at the GP surgery, than it does here?

HELEN: I think in private practice if it was instigated by the client, then I wouldn't block it, I would be allowing of it...but certainly in the my GP practice that I worked in, I don't recall any sort of humour. It was very much a formalised sort of session that we had.

HERMAN: I think personally, the only difference that strikes me immediately is that working with clients who aren't terminally ill, I encourage humour, I've got bits and pieces that allow a bit of fun to come in, um and I think humour is always really important...I think the humour is more raw with terminal patients and I think it's more honest

TED: the placement that I had was a private 6th form college, 16-19 year olds

RESEARCHER: And was there humour there?

TED: Well, yes and no, I think it's the same. I don't think it's necessarily unique to this setting, I really don't...I always describe my placement as...a baptism by fire. Here it's very controlled, you know generally speaking what you're getting. I think the humour was definitely there because I think again it's the same thing, I think it's the absurdities that people find they can laugh at something that's happened to them.

CAM: I'm not sure that there is, I can't think of anything [pauses]. Nothing jumps out. It wouldn't be right to say yes. Here, it's darker sometimes; definitely darker. You know what it reminds me of, it reminds me of European art house films - they're funny, but in that dark kind of, you squirm a bit, it's uncomfortable but it's not unpleasant, it's not nasty or malicious, or but it's close to the bone. I think French movies do that really well and the humour in a session with someone whose at end of life reminds me of that.

PENNY: I'm not sure that there is a difference. I wonder if it's more noticeable or feels more significant if it's a patient that uses humour because they're dying and so it's further away from where you might expect them to be, to be laughing and making a joke about something...I think it's more about the person, some use it quite a lot and some don't even crack a smile.

RUPERT: I've not noticed a difference, actually. There may be, but...no I think the things I've just said would've applied in the past with my with adult mental health patients and will apply with the distressed relative as much as it will with the patient. I think there may be some changes in the kind of humour. I think that somebody for whom death is getting reasonably close, may actually find that they are more inclined to dare to use a bit of black humour than they would have perhaps done previously, or certainly in my company would have dared to do previously, because there's something about the appropriateness of that they sometimes struggle with so even though it might cross their minds, they might censor it...So I think there may be a little bit more evidence of black humour...'I've gained the right to do this'. It's going to be more situation-bound - the idea that somebody being close to death, that may be causing them more distress, but as we know, that isn't necessarily the case. Sometimes the certainty that that provides is actually quite reassuring to people...so there may be other reasons why the person will find it harder to be humorous much more linked to other events that are going on in their life.

[Lights down stage right. DEATH, HUMOUR and THERAPIST resume].

DEATH: Perhaps it isn't down to just you and me? Are we putting too much pressure on ourselves?

HUMOUR: Maybe we are being too hard on ourselves. And each other.

DEATH: I'm sorry if I've been mean to you.

HUMOUR: Me too. I really shouldn't be so serious about things.

DEATH: It is a bit of a contradiction.

HUMOUR: [Smiles] Perhaps the problem's more with when or how people feel ok using me?

Scene 10: 'I may well use humour as well'

[Lights up stage right - HERMAN, HELEN, RUPERT, TED, PENNY and CAM, who sit opposite RESEARCHER.]

HELEN: I can tell when it's going to be ok to use it so whether it is something that the client instigates first, I think probably so because I'm not so sure I would just throw humour in. No I think it's something that the client instigates, and you know if that's then comfortable or alright to do so, based on the response.

HERMAN: Certainly when it comes to the clients we're talking about, I will always allow them to bring it in rather than me bringing it in, because that actually feels more respectful and more being there for them...A lot of it's spontaneous, and often, thinking about clients, you know it isn't like a 'boom boom', it isn't that sort of jokey humour that's coming through, it's very, very, very, very much rooted in reality and personal experience...For me I think my stance on it is it all being about relationship, if I can be in a relationship with a client and hold them, hold them in a way that allows them to be them, um then something good happens. I often don't understand what or why um but something good always seems to happen, actually for the both of us...I go with my gut feeling. I had one client who found it very difficult just to touch base with his feelings, it was just anger, anger anger, anger. It took a while before humour was allowed...it was very measured. I'm sure it was spontaneous but it didn't feel that somehow and I think it would have been wrong for me to introduce it because of where he was. And actually I think it's right for the client, the patient to take the lead in that. I think it's more about me responding in an open way, allowing the possibility, without pushing it.

TED: In my view, you can't just laugh about something, it has to be something that is brought to you by the client...I work with where they are. I don't come in saying, 'right then ok, lets cheer this situation up then, you know, let's have a laugh'...in the counselling room it's definitely client led. Because you could just be going down a route that they don't think is at all funny and I don't like to assume that just because I find it slightly amusing that they may not, whatever the subject would be that I might be bringing, they have a very symbolic meaning to them that's very, very upsetting...that's where I think doing it first is inappropriate...You're not there to make jokes.

CAM: I think the other difference depends on the demographic...This is going to be a generalisation, but when someone is from a working class background, there's more humour than if they are from middle, upper-middle and even upper class...those people who are of working class, that's been their way of communicating most of their life that they were brought up in a household where there was banter, and um mocking within the family, all done in quite a light-hearted way, the family units tend to be quite tight around the person whose dying and therefore that gives you an indication that this is a family that's been together for a long time. I would imagine that they've had jobs where they've been in organisations where it's not about being intellectual and talking about world affairs, politics, the latest play that's on at the Garrick theatre, and it's more about it's about humour and comedy and making each other laugh...It's a means of communication, I wonder if it's their own form of cheap entertainment as well because they don't, um, you know, do other things...And then when working with the let's say the upper middle class, they

tend to be more serious and more pragmatic and matter of fact and what they can do very well is tell you what the consultant has told them but its then very difficult to access them at that emotional level, that ‘what is this like for you?’

PENNY: I know this particular client very well now, so I know that she uses humour, and because I know her well, I may well use humour as well with her. If I don’t know them very well...I wouldn’t go ‘you said something awful and yet I notice you laugh’ because actually that’s quite a challenging remark, but I would clock that, that these are emotions that they’re clearly struggling with and they don’t know what to do with them and I’m getting what could be considered as an inappropriate response...and then when I get to know them better if they’re still doing it, then I’d say whatever would seem appropriate. I think I use humour though, or might use it, as an ice-breaker. It might be from when I meet them to where we end up sitting down...I mean certainly if they bring it up then it’s an invitation to either join in the humour or not, whichever feels more appropriate. I can’t think of examples but I don’t think I could categorically say that I don’t, that I always wait for the client. I think, I think I might if it, but then I’m thinking so when might I, um, I don’t know because it’s in the moment isn’t it?

RUPERT: Often my opening remark to somebody is, ‘what brings you to my door?’ and sometimes they will take that in a humorous way and sometimes they will take it very seriously, and I just take my cue from them at that point.

[Lights down stage right. DEATH, HUMOUR and THERAPIST resume.]

THERAPIST: It occurs to me that you are finding a middle ground to discuss your issues. How are you both feeling now?

DEATH: I’m feeling better.

HUMOUR: What doesn’t kill us makes us stronger.

DEATH: Ahem.

HUMOUR: Sorry, I couldn’t resist.

DEATH: It’s fine, I like seeing you back to your old self. Maybe we should stop blaming each other?

HUMOUR: I agree. There’s only so much we can control. I think we need to let go of what we cannot.

DEATH: Maybe we need to look at how we are in other situations – outside of what these people are doing with their clients, or how their clients experience us when they’re not with their therapists?

THERAPIST: There’s a world outside the consulting room?

HUMOUR: [Smiles] Very good.

Scene 11: ‘Out there, it’s not counselling’

[Lights up stage right - HERMAN, HELEN, RUPERT, TED, PENNY and CAM, who sit opposite RESEARCHER.]

HELEN: There’s almost an expectation about humour, and in that respect I know even at the hospice we used to refer to it as a black humour because we could find humour in a situation that actually anyone on the outside might think ‘what on earth are you laughing at’...

RESEARCHER: Do you mean with the client, or more generally at work?

HELEN: I think as a work team. If someone was listening in or perhaps a fly on the wall, they might think 'oo'.

HERMAN: With one patient, he's always been the joking one at work and at home, but I don't think he can do that or be that anymore, so he has to use humour in a different way I think...what I understand from what he was saying is that they still find it quite difficult to engage at that level as they would have done before. I've been in the family unit at home so it sorta becomes more apparent that humour in the family home doesn't exist, it all feels very heavy, very serious, you know, lots of anger, lots of despair, lots of pre-empted loss feelings...and I'm not sure he has the outlet or permission to be humorous....actually I think he finds it very difficult with his wife to be humorous because you know their relationship has changed so enormously because of her becoming the carer, him becoming totally incapacitated, and that takes something away with the fun of life, I think, because that translates into the inability to be humorous...in the same way that with that very first client I was talking about that I was protective of, not wanting to upset or distress by being humorous disrespectfully, I think he has the same approach with his family...It's interesting 'cause as a team, we're very humorous. I think there's a lot of banter that goes around but it's sort of safe because it's away from people who might become distressed by that sort of humour. But I think that's true of every sort of role that involves death and dying. I mean when you come away from the actual front line, I think there is a lot of black humour. There's a sort of way of being able to cope with the feelings that are attached and normalise...and that's a similar thing around sex, there's almost a taboo. Humour and death [winces].

DEATH: Ouch!

HUMOUR: I know, right? We're not that bad!

DEATH: And the sex isn't either.

TED: Outside of the counselling room, of course I will because then that would be completely normal, because out there, it's not counselling. We could be talking about the car parking walking down the corridor to the room at the time and 'bloody hell it's raining again' and you know it's a little bit of banter in humour, being a human being...I suppose because I'm quite a chatty sort of bubbly person anyway, I've watched counsellors walk down the corridor in absolute silence, and I think 'oh can't you just be human' you know, 'hello, how are you?' just be human, you know, 'is your path alright? Isn't the weather rubbish, cor it's wet today' you know, do you have to walk past with a 'did you get wet on the way here?' 'oh yeah, you know, I left my brolly at home as well and' it just humanises then you come in and sit down...And then it changes. Then we get out again, we might walk out that door, and it's a sort of barrier it changes the atmosphere out there.

CAM: Of all the different settings I've worked in, the hospice has the best sense of humour amongst staff and volunteers and as an organisation. There's so much laughter on that ward in the different rooms that I go into, both patient rooms and staff rooms and clinical meetings and so I think it is important. I sprayed air freshener once, and a colleague commented, 'smelt like death?' [laughs]. So there's lots of death jokes. When I first started working here and there were jokes and things, I did think 'oh god, that's a bit' but now it's in for a penny in

for a pound. In fact in some ways, it's almost like, who can out shock the other. There's often talk, people will say things like 'god, I ought to get on and get married', 'oh have you got anyone in mind', 'no but I've gotta have kids, whose gonna look after me when I'm dying?' I don't know what you call it, but we're laughing at ourselves. But are we, as well? Because as a therapist, there's an unconscious process there as well. You're laughing but you do mean it is as well. Shit, who is going to look after me when I'm older 'cause I see what it's like when people don't have family. So there's that fine line sometimes where the laughter is...Clients find it difficult to use humour outside of therapy sometimes though...a lot of them talk about how they become their illness, they're defined by that, so their families treat them very differently and so do their friends, there's a bit of avoidance so friends will stay away, others are a bit imposing, and you know classically, friends and family want to rescue, they want to cure, and they want to diminish it. And what a lot of patients tell me is that they never have any fun anymore...

RESEARCHER: How about the relatives?

CAM: Well the relatives, I feel that they sometimes have to use humour and that is as a coping strategy...Sometimes if someone is dying and they're in their last hours, then you hear relatives reminiscing about times gone by and they'll have a laugh...And what you see is really quite beautiful but very painful, how they laugh themselves into crying and then from the crying they'll pull themselves back into laughing and it's so interesting how those two emotions sit next to each other. It's amazing. It's amazing.

PENNY: Oh we use humour bit like nurses humour, outrageous, [laughs] absolutely outrageous. If a fly on the wall would hear the conversations and some of the things that we laugh at, and they're not funny, and then we use it quite differently, we use it because actually to deal with death and dying you know, five days a week and sit with people who are dying if not imminently or people who've had so much loss and there's just one more coming and sometimes it, it is a burden to carry and it's a way of trying to shift some of that...And the difference in the team is that nobody would ever think that the humour was in any way dismissive or unfeeling or not compassionate...it's a way of coping, so you can go back to the next one. And there's quite a lot of laughter around the hospice generally, so you go in the coffee shop and you hear people laughing, or walk through the corridor, as we did, or at reception and there'll be a laugh. And people are surprised and actually the clients who talk to me about it will say that it's a really nice atmosphere and they come in and it's a sigh of relief really that there's somewhere where there's someone who can look after them, so it's interesting that laughter can be part of that and people will still feel looked after and taken seriously and what have you.

RUPERT: When I'm teaching the same thing will apply, I will often like to start with something that will, yes, raise a little bit of a smile. It may not be brilliantly funny, but just produces that little bit of relaxation. I think we all relax a little more when we are amused.

[Lights down stage right. DEATH, HUMOUR and THERAPIST resume.]

HUMOUR: I think I've had a...what do you call it? A breakthrough? People don't like using me in certain situations, which now I think about it, makes perfect sense. In other situations, I am completely necessary. Perhaps I should settle for that?

Scene 12: 'Humour in supervision, absolutely!'

[Lights up stage right – HERMAN, TED, PENNY and CAM, who sit opposite RESEARCHER.]

HERMAN: That first client I told you about...it was one of those things I just had to take to supervision because what the hell do I do? I had that supervision session 'Oh, I don't know how to handle this, I'm finding it really, really, really quite tough' and very quickly came to realise with a very good supervisor saying 'why can't you just be you, and why can't you just let him be him? What are you worried about, what's going on?'

TED: But as a supervisor, my supervision sessions are always fun because they've got to be fun because I strongly believe that if people don't enjoy something they won't learn...When I was training, one of the things that my supervisor at the time...who is the supervisor I have now...he said 'there's always one thing I remembered about you' he said 'and that is your use of humour and how humour works with your clients' and I'd completely forgotten about this and he said to me...'I now use it in my training', and he says it was me that had brought that to him as an option.

CAM: I've noticed as well that the students that I supervise, they pick up on the need to use humour quite quickly as well. They come here quite seriously but even in our clinical supervision, I find that it's lighter and there's a bit more banter in it than there is in other settings. One student said to me something like 'and the client and I were laughing and the client was joking and it was really funny – is that alright?' and I said to her, 'clients don't just come to therapy to be miserable'. You can't just be miserable and therapy's not just looking at the miserable stuff.

PENNY: Humour in supervision, absolutely. So supervision as a learning environment, absolutely that's a good place to learn and to take that the fact that your client laughs from the moment they arrive to the moment they leave, and what's that?

[Lights down stage right. DEATH, HUMOUR and THERAPIST resume.]

DEATH: I feel like we've got quite far today.

HUMOUR: Yeah, thank you!

THERAPIST: I feel I ought to be thanking you – there's quite a lot I've learned today myself.

Scene 13: 'My learning is...'

[Lights up stage right - HERMAN, HELEN, TED, PENNY and CAM, who sit opposite RESEARCHER.]

HELEN: You know when someone says 'don't look' and you automatically do, I unfortunately can fall into that trap very quickly, so if someone had said 'don't mention the war' I can guarantee I'd be saying something about the war, or the Germans and England. I don't know what it is, there's a part of me that gets drawn to it...humour for me, sometimes I can be caught out with it, so I'm very careful now because there were obviously past events when I was doing my

nursing [talks in depth about two particular instances, and both Helen and Researcher laugh. A lot.] but I like humour, I do use humour every day.

HERMAN: I'll name humour for what it is rather than trying to avoid it. I think it's freed me from the shackles of what we consider to be appropriate or respectful or honouring or whatever it may be. It was a big learning curve for me I think...and it's made me more open to it...In all my other work it's allowed me to be that much more open and accessible to the humour...I think that it would actually be impossible to do any sort of terminal work without humour. Actually, impossible to do anything therapeutic work without humour. It's an important part of therapy I think. Essential part of therapy I think. It reminds me of my own therapy with a gestalt therapist where I was allowed to choose toys, one that represented myself, one that represented my therapist and one that represented the process for me...I wonder, it just strikes me, I wonder how that might work in working with a terminally ill client. There's something about the appropriateness or inappropriateness of using that perhaps.

RESEARCHER: That reminds me of how you felt with that first client and humour

HERMAN: It feels comfortable doing that in a normal session. A normal session? They're all normal sessions, but you know it's about respect, it's about respecting the end of life. And do toys do that? But why wouldn't they? It's an interesting question for me to hold.

TED: I think because of the experience I've now got, I understand what people go through and I haven't experienced what people go through, yet, and hopefully I won't...but I've seen an awful lot and I've heard an awful lot of stories over the years, so I think I've tended to learn where humour is appropriate and where it is not and to be able to pick up um the right time for it or not the right time for it.

PENNY: I'll probably find now I use it completely differently to how I thought I did. I shall be a bit more aware. And noticing that either I do it more than I realised and you know I and when I do it. Yeah, I'll let you know. I'll be a bit more conscious of it.

CAM: This is the most life affirming place to work, because the people that I work with teach me more about life because they're at the end of life...they do inspire. And they've got me to change my life. And I think I'm a bit more light-hearted actually as a result. Um, I think my sense of humour has changed since I've worked here. I give myself permission. If I was in a room in a hospice and I was at the end of life stage, what might I like to hear? And I think I'd quite like to hear laughter and music...My learning is don't take life so seriously, and as a result, don't take death so seriously either. Or be lighter with it. Because you can't do anything about it.

RESEARCHER: That's great – thank you!

CAM: Before we end, let me just go through some of these notes and see if I have any examples of jokes for you. [Rifles through files.] You know as I'm going through these, I think the last thing to say is that actually a sense of humour is not that common. I mean what I've been talking about is probably 3 or 4 patients out of hundreds. It surprises me. Yeah, I'm going to go on record as saying that that surprises me. As I go through the files now, sense of humour – actually that person's got a sense of humour. But he's a personality disorder so maybe that's got something to do with it. No it's not that common. That's one out of um, two out of a hundred maybe. It's not that common.

[Lights down stage right. DEATH, HUMOUR and THERAPIST resume.]

THERAPIST: With all these examples of therapists, I do wonder what you think has been happening in the room here with me, but our time is up. Will I be seeing you next week?

DEATH: It will not be that soon...Just joking.

Fin.

Chapter 7: Analysis

“In tragedy we cannot imitate several lines of actions carried on at one and the same time; we must confine ourselves to the action on the stage and the part taken by the players. But in epic poetry, owing to the narrative form, many events simultaneously transacted can be presented”

- Aristotle (trans. 2003:57)

7.1 Introduction

The purpose of this chapter is to portray an analysis of the findings. With no clear guidelines from Bruner as to how to analyse findings, the researcher was free to implement a myriad of different methods. After several failed attempts at trying to analyse findings without ‘killing the joke’ as it were, the decision was made to focus on the key components of narrative, which include character, plot, temporality and situatedness. Attention has been paid here to not only the content of the participants’ stories, but also how they were told, and in accordance with Polkinghorne (1995:16), a “to-and-fro movement from parts to whole that is involved in comprehending a finished text”. The ‘whole’ of the stories combined will thus be compared to the individual parts of participants’ stories. It is to be acknowledged that what follows is only one story, from a multitude that could be told, of a researcher’s re-telling of her participants’ stories, as Bruner (2004:709) states, “any story one may tell about anything is better understood by considering other possible ways in which it can be told”.

7.1.1 Characters

The characters of our story are six therapists, the researcher, and also the clients, supervisors and work colleagues that are introduced in the vignettes presented by the therapists. At times, humour and death also become personified as characters through ‘death knocking on [clients’] doors every night’ (Cam) and ‘humour...touch[ing] the person’ (Herman). The text encompasses a range of experiences with Rupert being the

longest standing therapist in the group, and also the only one who identifies himself as a counselling psychologist, compared to the other five who consider themselves primarily to be counsellors. Next is Helen, who has twenty-five years of experience in palliative care, though with only seven of these being a counsellor in this setting. Penny and Ted both have approximately ten years of experience, followed by Herman with five years, and the 'youngest' of the group being Cam, with two years. An appreciation of the length of time they have been practicing as palliative therapists provides a context to their stories and has potential implications in what meaning they make and what they learn from their experiences.

In narrative tradition, these characters can be seen as heroes, villains and victims. In first reading the stories, we might think that it is humour that is the hero, backed by the army of supervisors and work colleagues that make his fight against death, the villain, an easier one, ultimately to salvage the therapists and clients, both of whom appear to be victims. On deeper inspection of each individual story, however, we can see that these roles are much more transient. Herman, for example, begins his journey with his first client and death being victims of the villainary nature of himself and humour, 'I felt the need to be guarded with my first terminal client, not saying anything that might be offensive or make light...the presence of humour somehow undermined the seriousness of what [the client was] going through'. In turn, his client becomes the hero, allowing him to 'work through this' and thus hands over the heroic baton to Herman himself, who is able to be more present for his other clients: 'humour helps treat the client like a person, not like a dying person...I can be me. And that also I think helps the client to be them', ultimately slaying the villain, death. Ted, on the other hand, could be seen as a hero throughout his story. He starts working in palliative care with humour on his side, 'my sense of humour was

important when I started working here’, eventually arriving at a destination where he influences his supervisor’s practice, ‘he says it was me that had brought [humour] to him as an option’.

At times, the researcher is called into position. Though the first person is being used in participants’ stories the majority of the time, implying an ownership over their experiences, there are also instances when the researcher becomes more than just a silent listener and instead, much more a part of the story, interweaving her role of being an interviewer or hearer of these stories, a therapist in a palliative care setting, and ultimately, the writer of this story. This can be seen in the participants’ use of ‘you’ or ‘we’. Some examples are Helen’s ‘so just as you’ve laughed there, that was the nature of the session’; Herman’s ‘certainly when it comes to the client’s we’re talking about’ or ‘what that something is I can’t tell you’; Cam’s ‘you can hear, can’t you sometimes, if a laugh is not natural’; and Rupert’s ‘but as we know, that isn’t necessarily the case’ or ‘that’s why they’re going to see you or I’.

There are also those instances when participants use the second person almost as an instruction to the researcher: ‘when people are dying, you can’t be humorous’ (Herman) or ‘you can’t maintain that...you have to temper it with humour’ (Cam), or ‘you have to be more cautious’ (Helen). These instances can perhaps be a way of participants distancing themselves from their experiences, as is their use of ‘we’, implying they feel part of something bigger than themselves. It appears that mostly Herman uses ‘we’ in this way: ‘we’re looking to improve a client’s understanding of himself’ and ‘we don’t use humour because we think that’s honouring’. Other instances of ‘we’ are used only by Ted and Cam, specifically when talking about the usefulness of humour: ‘we need to be inclusive of all the client brings’ (Ted) and ‘we don’t have time sometimes...if we treat people as they are, we make them worse. If

we treat people as they ought to be, we help them to become what they are capable of becoming' (Cam). In one interesting moment in Herman's story, all of these cases are apparent in the phrase: 'you know, humour helps the client live as freely as we can...because I'm not dead yet!'

The protean roles of the characters potentially demonstrate the complex way in which the therapists, through the reflective act of telling their stories, portray their sense of self. As Bruner (2004:4) states, "self-making is, after all, our principal means for establishing our uniqueness, and a moment's thought makes plain that we distinguish ourselves from others by comparing our accounts of ourselves with the accounts that others give us of themselves".

7.2 Plot

Harkening back to Aristotle's depiction of typical Greek tragedies and comedies, which was explored in Chapter 2, tragedies were considered to have a particular structure in which characters experienced a reversal of fortune, which in turn resulted in a combat between two contending forces and ended in a lamentable death, resulting ultimately in "a change from ignorance to knowledge" (Aristotle, trans. 2003:33). The tragedies were followed in performance by a 'satyr', which made fun of the seriousness of the three plays that preceded it. Potentially, what is presented in this thesis as Chapter 6 could be seen as the 'satyr', however there were also instances during the interviews in which both researcher and participant laughed, and anecdotal stories of clients' situations. In considering including these into either the findings or analysis, it was felt by the researcher that these anecdotes appeared to contain information that could potentially compromise the anonymity of the participant due to the highly contextual nature of humour. Further, there was enough consideration of

how the therapists in this research experience humour for the anecdotes not to be needed, and as such it was felt that they would be alluded to in this chapter instead.

7.2.1 Reversal of fortune

The reversal of fortune can firstly be seen in those clients with a terminal diagnosis. All the therapists other than Penny refer to the sense of devastation that their clients and those around them experience. ‘Client’s gonna die. They know they’re gonna die’, Herman hopelessly acknowledges; the clients are ‘deathly sad, sad, desperately sad’, says Ted. Herman, Cam and Rupert however are the only three to discuss the implications that this has in their therapy, either by calling into question the nature and outcome of therapy (for Herman), or by shaping or taking something away from the nature of the work that can be done in these circumstances (for Cam and Rupert).

There is also the reversal of fortune of those therapists that had certain preconceptions of working in palliative care, preconceptions brewed with therapists’ training and societal expectations that almost deny humour any invitations when death is around; indeed, for Ted, death cannot even be spoken of. These preconceptions, which could potentially be seen as the therapist’s hamartia, are later challenged by either starting work (for Cam), or those clients that try to use humour and catch the therapist off-guard (for Herman), at which point humour permeates and becomes a kin, and therapists are unshackled from their preconceptions. Herman, for instance, speaks at great length about being guarded with the first terminal client of his who used humour, not wanting to offend. A large part of his story is overcoming this struggle, and recognising the potentially detrimental effect that his struggle itself has on this client, which offers him the learning with which he approaches humour with other clients. As his story continues, he uses this client as a benchmark against which to measure his ‘progress’ in terms of being comfortable using humour. Penny mirrors

these thoughts in discussing how, with experience, she is better able to manage the ‘distraction’ that humour affords. Lastly, Cam, despite being in practice for a relatively shorter time, acknowledges that he would not have used humour right away but has learned to be lighter.

This reversal can also be seen in how therapists speak of their first few sessions with clients, with Helen and Rupert also joining the conversation. It is here that we start to see differences in each therapist’s experience. Helen is quite clear about the lack of humour in the first few sessions, which although initially in agreement with Herman’s experience, contrasts with what he says about humour being present in the ‘very first session’ with terminal clients, albeit to ‘test’ the therapist. Rupert’s comments contrast even more with Helen’s in feeling that humour’s role is almost to put his clients at ease in the first few sessions, with this being less of a necessity as time goes on. Cam’s glib statement of the potential for humour to be there at times and not at others is felt to perhaps be the most balanced.

7.2.2 Struggle between contending forces

The two forces that are struggled with are most apparent in the battle between humour and death. The therapists speaking of their own personal experience of humour is one way of exploring this. Cam, Herman and Ted are the only three that discuss humour outside of their work setting, and how this impacts on their practice with terminally ill clients. Both Herman and Cam’s personal experiences of bereavement in the family seem to elicit humour, which in turn helped cope with their feelings of grief, and there is acknowledgement from Ted of the helpfulness of his own personality. There is an acknowledgement from Herman though, of how working with clients is somehow different: ‘my personal experience of humour doesn’t translate quite so easily when

you're with a client. The prior is fine because that was about me, but with clients, it's constantly being aware of those boundaries and sort of trying to hold them'.

This struggle is also apparent in those therapists that speak of their experiences of humour with terminally ill clients compared to those in other settings. Helen stands alone in this discussion, not noticing humour's presence elsewhere, but also believing that her work in palliative care was less formal. This is in contrast to Ted, who feels that working with terminally ill clients is in fact more controlled, and is certain that humour was present in other settings. Herman agrees with the presence of humour in other settings and goes as far as to say that he works at introducing it with his other clients, despite having discussed his immense struggle of using humour when it is in the room with death. Cam, Penny and Rupert's comment are almost identical in not necessarily noticing a difference in the amount of humour that is present with terminally ill clients, but noticing substantial differences in the type of humour that is around.

There is also a notable struggle between client and therapist in initiating humour. Helen, Herman, Ted and Rupert appear certain that it ought to be the client that initiates the humour. Penny stands aside in some ways; not being able to say categorically whether she initiates humour or waits for a client to, although she is certain that she might say something humorous before the session formally starts. Cam's comment is the most different in acknowledging the context of culture and class, with an implication that he might perhaps use humour to break the guardedness of some of his clients.

The struggle between therapist and death, or client and death, is also prevalent in the therapists' stories, in speaking of how they and their clients experience humour outside the consulting room. Helen, Herman, Cam and Penny all speak of their work

environments being consumed by a very private sense of laughter, almost as a necessity to help cope with the nature of working in terminal care. Penny also comments on how this could potentially be distracting or avoiding an issue, whereas Cam feels that the humour also acts as a way of acknowledging the reality of the situation his colleagues find themselves in. Ted and Rupert both highlight their experience of humour with the client outside of the consulting room and how this humanises the therapist or helps the client to relax. Herman and Cam are the only two to talk in detail about their clients' experiences of humour outside of the therapeutic space, both sensing that clients with terminal illness are potentially disallowed from being humorous. For Herman, this mirrors the sense of disrespect he felt when considering humour with his first terminally ill client. Similarly, Herman, Ted, Cam and Penny all acknowledge a strong presence of humour in supervision, and speak in different ways of how supervision 'allows' humour to be present with clients. Particularly for Herman, supervision gives him permission to be himself and let the clients be themselves; and, for Ted, his own use of humour not only influences himself as a supervisor, but made a lasting impact on his own supervisor.

7.2.3 The death

The 'deaths' that occur in these therapists' stories could be interpreted as the death of death, in which humour is the killer; the death of humour, in deathly situations; and the death of therapists', particularly Cam's, views regarding the prevalence of humour. In considering the death of death, all the therapists speak of those moments where humour was a positive experience. Herman, Ted, Cam and Rupert all agree that acknowledging humour in sessions is acknowledgement of the 'whole' of the client, and the humanness of both client and therapist. All six participants speak compellingly about the positive aspects of humour and list the beneficial outcomes

that are discussed in Chapter 2, such as relieving tension, means to communicating something which is otherwise difficult to communicate, encouraging an empathic relationship, engendering trust, recognising absurdities.

The death of humour occurs when all six of the participants are able to identify experiences of struggling with humour. They each speak of knowing when not to use it, and in Penny's case, knowing what humour is not. There is a sense in Rupert's experience of needing to 'take control' of humour at times, and of clients feeling obligated to 'look after' the therapist. The participants experience humour as distracting, insulting and defensive.

Lastly, Cam reports on how his sense of humour with clients has changed his sense of humour as a person. He's learned not to take life or death too seriously, but most surprisingly of all, he spends the majority of his interview discussing how prevalent humour is, at the end to land with a bump and realise that out of around a hundred clients, only two clients could be identified as using humour.

7.2.4 Revelation and recognition

Having fought the battle, the therapists, in telling their stories, arrive at a place where they seem to summarise what they have learned as therapists in palliative environments and as a result of being interviewed, and where this might take them next. Helen ends her interview with the beginning of her experience of working with terminally ill clients, with two examples of how she caught herself out with humour – not being allowed to say or do something, and finding herself doing exactly that, and how she has learned to be careful with that now. Herman speaks of feeling 'freed from the shackles', and as a result, more open to using humour, not just with terminally ill clients but others too. Interestingly, he still seems to keep his terminal clients in some sort of compartment, where he almost considers sessions with them

not to be 'normal' in some way, and not being able to use the same sorts of interventions that he might with others. Ted has learned from his experiences when to use humour and when not to, and whilst Penny becomes very certain in her interview of what humour was not, or when she might not use it, she acknowledges that as a result of being interviewed, she would be more conscious of her use of humour.

7.3 Temporality

Temporality is a significant feature of the therapists' narratives, which feels particularly apt given the nature of humour, as Penny states, 'it's in the moment isn't it? It's in the moment', and the finitude that clients with terminal illness are confronted with. Considering the temporal dimensions in which the participants speak potentially provides an insight into how they experience humour with clients diagnosed with a terminal illness.

Throughout their stories, the therapists mention time in terms of their employment history, their early experiences of working in a hospice, the amount of sessions they might have had with a client, humour in early sessions compared to humour as the therapeutic relationship is developed, and the temporality that is terminated with a terminal diagnosis with particular exploration of clients' changing sense of time. Looking at the transcripts overall, the stories appear linear, describing therapists' personal experiences of humour prior to working in a terminal care setting, followed by the preconceptions that being a therapist in such a setting might bring, to how their experiences have altered the preconceptions, and finally their learnings. This perceivably ordered chronology highlights participants' sense of objective time, with stories that are almost exclusively located in the present, giving the sense of a real primacy of experiencing.

In looking at individual stories, however, there are distortions to the chronology in their stories of anticipations, events and memories which provide a complexity to each therapist's subjective sense of time without perhaps the narrator having any direct responsibility for any of them, since they are, in a way, already part of the story. Helen's interview, for example, ends at the beginning of her experiencing where she tells stories of humour whilst working with terminally ill patients prior to being a therapist. Her ending statement is 'those were obviously past events when I was doing my nursing, but I like humour, I do use humour in the every day.'

Interestingly for the researcher, Herman's discussions about the future are very much located in the present tense, for instance, 'it's the lack of hope that you have in terms of someone being able to go on and live a full life...a full life for me is hopefully another 10, 20, 30, 40 years...that isn't the way for the client...they may have 6 months or whatever it may be, so that longevity isn't there' and 'he's also very aware of protecting his wife from her impending loss, it's not just his loss of his life bit it's her loss of him as well as his children's loss.' There are also instances where Herman is very much in the present moment, 'now it feels more genuine', as well as conveying his client's immediate consciousness about the fragility of their existence: 'you reach a certain age in life, you know and you suddenly say 'I can say whatever I like because I've earned the right to do it''.

Ted shows similar distortions of past, present and future when he remembers working with clients: 'I'd been seeing him for 18 months now...he was beginning to get there now' as well as, 'once you've talked about it a few times and he starts to see how silly it is, he can see and then he will bring me humour'. There's also the instance when Ted describes working with his supervisor which on first listening to the interview, sounded to the researcher to be relatively confusing: 'when I first when

I was training, one of the things that my supervisor at the time, um is the supervisor I have now, I went back to him, um, in the mean time as a volunteer for 7/8 years before I was employed which was three years ago December, um...um, um and one of the things I went back to my supervisor when I was employed here so I've been seeing him for nearly three years again now. He said to me, he said 'there's one thing I remember about you' coz obviously this is sort of 2003, so we're talking 8/9 years before, he said...'.

For Cam, the few instances where he does use the past tense refer to clients' stories, early preconceptions about working in palliative settings or his personal experiences of death. The future in Cam's text however, can be seen in instances where Cam 'breaks' his story by almost suddenly realising the immediacy of his position as a therapist being interviewed by the researcher. For instance, '...the more guarded a person, and that can, actually, I'm going somewhere and no, I'm going to change my mind' and later, 'I am going to give you specifics so you will need to edit it'. Penny can be seen to do something similar when she dances between past and present in conveying her interpretation of the interview: 'what I didn't want to put across was that either I use humour as a way of kind of wanting to be buddies, because it isn't that, or that I used humour as a way of lightening the mood because actually it was too heavy to hold, I don't mean that either'. This is in contrast to Rupert's story which uses future tense more than any other participant's: 'I will always try with people to put them at their ease by being as friendly and relaxed as I possibly can', 'it will have got things to think about and they will have perhaps things to do that are quite challenging', 'we will also see these people going through quite these significant mood swings' and 'you will start to worry whether the session has been started to engineer around it'.

The distortions of time in participants' narratives disrupt the uniformity of direction. In those instances where the stories are straightforward, the hearer is completely informed of the progress of therapists' experiences to the extent that in reading the transcript, the researcher's interpretations were projected to the future with a sense of suspense. However, when the chronology is complicated or confusing, the suspense, for the researcher at least, is paired with a curiosity as to how the nature of the past might reveal the present, and how the past and present come back on themselves and reveal how they have a hold on the future.

7.4 Situatedness

Participants' stories are grounded in the specific contexts in which their stories occur, which in turn provide context to their experiences of humour with terminally ill clients, and are worthy of consideration given the contextual nature of humour.

The 'situation' that participants refer to include their situation as therapists working for terminally ill clients compared to being in other settings. For Helen, for example, the palliative setting, which affords her the ability to see clients in their own home, feels less formal and hence contains more humour than her previous experience of being a counsellor in a GP surgery. Ted, on the other hand, spent the first 130 lines of his interview speaking about how he became situated as a counsellor in his palliative care setting, and felt that working there was more 'controlled' because 'generally speaking, you know what you're gonna get.' Herman refers to his client's experience of his situation as a counsellor who, at least initially, felt unable to respond to the humour in the room: 'he said 'I wanted it to be slightly more light-hearted', he said 'and I kept trying', you know, bless him [laughs] you know, 'and then I thought to myself, 'god, you're the bloody therapist here not me!'''. This can also be seen in Helen's story in discussing clients' experiences of boundaries, 'sometimes with some

people they don't understand the boundaries or the um where a line might be drawn or if they've crossed it'. This brings in the situation of being in a therapeutic relationship, where all participants agreed that the stronger the relationship, the more able they felt to use humour and respond to it appropriately. Related to this are the situations of humour for the therapist and client both inside the therapy room, outside the therapy room, and separated from each other such as with colleagues (for the therapist) or family and friends (for both therapist and client); and, situations where the therapists were new in palliative settings with all the anticipations that brought to them, compared to being experienced therapists and what they have learned as a result.

There is also the 'situations' that clients find themselves in. There are numerous anecdotes that the therapists refer to in which clients find themselves physically in awkward situations, which Ted refers to as 'absurdities', however also the situation they find themselves in as a result of their diagnoses. Physically, participants referred to clients being bed bound, or having labile emotions as a result of a particular diagnosis. However the therapists also explored clients' emotional response to where they found themselves as a result of being confronted by death, and others' reaction to this: 'I won't say anything I'll stay away, I won't say anything I'll stay over here' (Ted).

There is also the cultural situation that the therapists are speaking from, though only Ted, Herman and Cam refer to this. Ted and Herman both experienced the British culture in which they practice to have not only expectations for people diagnosed with terminal illnesses, in which both humour and death are taboos, 'the vitality gets buried' (Herman) and neither patient nor therapist might feel free to experience humour as they wish. Whilst Cam agrees with this, the cultural context of

his experiences ran deeper. Although he is hesitant in disclosing his observations, he eventually portrays the classist deviations of humour between those of an upper class who have a 'stiff upper lip' and with whom it is harder to gather information from, 'you really have to pull it out of them', and the lower classes, where 'humour is part of their everyday'. Cam also refers to the historicity of this observation, laying it down to the 'blitz spirit': 'but that must have been awful! You're having bombs dropped on your head night after night. And I wonder if that's similar, that it's a survival technique, a coping mechanism to be bright and breezy and rally round'.

Lastly, there is the situation in which the therapists are participants of a research project being interviewed. There are several occasions in which their stories are halted by a realisation of this. Helen for example, after being asked if she had anything to add, laughingly responded: 'I don't know. Have I still got a job?'. This is the most apparent in Cam's interview when half way through, he asks what the title of the thesis will be in order to see if he can think of any further examples, and when he realises he is about to make a generalisation, such as with his comment about the class system and stops himself, as well as toward the end when he looks through his client notes to see if he can find anything relevant.

Chapter 8: Critique

“DEATH stands for ‘don’t expect a tragedy here’”

- Busey (2014)

8.1 Introduction

The aim of this research was to explore psychological therapists’ experiences of humour in sessions with clients diagnosed with a terminal illness through exploring how tragedy and comedy present themselves in the therapeutic space. With the vast body of work carried out on death and humour, this thesis begins with one history - of many that could be told - of societal attitudes and the situatedness of each of these two phenomena in society today, together with the implications this has on therapists working with terminally ill clients. With previous literature providing a context, Bruner’s (1991, 2004) narrative method was utilised as a vehicle of exploration, the effectiveness of which will be evaluated below. This is followed by a discussion regarding possible future research.

8.2 What was gained and what was lost?

In answering the question of what is the relationship between humour, terminal illness and psychological therapy, the literature search illustrated that the phenomena of humour and death provide a vast area of potential exploration through which there are many stories that could have been told. It therefore became necessary to establish what this thesis is a story of, what was meant by comedy, what was meant by tragedy, and to locate them in the psychological therapies. In doing so, each of these different aspects were examined in the literature review by looking at what was already established in current research, which in turn served to justify this thesis. Whilst there is a plethora of literature on each of the disparate elements of humour, terminal illness

and psychological therapy, as well as on the relationship between any two of them, what was found to emerge when the three were placed together as a triad was something very different and underreported. Considering the literature in this hermeneutic way harmonised with the narrative tradition by examining how each of the individual parts informed the whole, and in turn, how the whole informed each of the parts, for the whole story never coherently tells the story of the individual parts just as the parts never tell the story of the coherent whole (Gadamer, 1975). Further, in considering the psychoanalytic stronghold over existing literature, and attempting to tell a more ‘existential’ story, this thesis builds on yet is distinct from research that already exists.

So what is the story that has been told here? Firstly, it is a story rooted in Western culture and a specific point in history. Further, the majority of previous stories looking at humour, death and therapy have been told through a psychoanalytic lens. Whilst there was a desire here to step aside from that and tell a new story, the dominance of the psychoanalytic story could not be ignored. Therefore what is told is a story that maintains the existential tenets of subjectivity and intersubjectivity. The springboard of exploration has been Aristotle’s depictions of Ancient Greek tragedy and comedy that show the human propensity to combat the tragic with the comic. Tragedy, potentially as a means through which to explore man’s limitations such as in Prometheus’s story, is mirrored particularly in Herman’s use of metaphors in describing his terminal patients as having ‘chains of expectation’ and himself being ‘shackled’ when he was face-to-face with a funny, dying client. The idea of comedy freeing one from limitations is reflected in all the participants who compellingly put forward the benefits of humour in their practice. This in turn supports the plethora of literature that lists the beneficial aspects of humour (e.g. Pierce, 1985; Mann, 1991;

Bader, 1993; Stephenson, 1993; Erdman, 1994; Goldin & Bordin, 1999; Ortiz, 2000; Fabian, 2002; Newirth, 2006a; Lothane, 2008b). Participants' experiences before starting work with terminally ill clients are also supportive of what previous literature has said about the preconception of therapy being 'serious' (e.g. Lemma, 2000).

However, the enormous body of literature exploring death and humour implies that maybe this topic is too big: in earlier versions of this thesis, some of what was noticed was that the researcher's voice was missing, which leads to the possible interpretation that there is something about this subject that feels bigger than just one person. On one extreme, humour is subjective and death is the only thing we go through completely on our own. On the other hand, death is the one thing that everybody will experience, and humour too is universal, dialogic and relational. What has been attempted through approaching this through a narrative research method is to put a voice to these. Choosing narrative then, with the focus being on one person's story – in this case, the author's - makes the enormity of the topic with the individualism of experience difficult to reconcile.

In attempting to find a 'voice' through which to tell the story that has been told here, the author kept returning to the metaphor of a journey, the seeds of which were implanted when she heard the Rolling Stones song 'Laugh, I nearly died' (for instance, participants telling the researcher of their credentials could be likened to 'checking into the flight'; their difficulties of working with terminal clients could be likened to 'turbulence'; and, their experiences of supervision could have been 'assistance from the steward'). What became apparent in attempting to write first the findings and then the analysis in this way was that this was a metaphor superimposed upon the transcripts by the author. There was nothing in participants' stories that overwhelmingly lent itself to the metaphor of a plane journey, and as such it was

realised that although narrative research allows for the researcher to be placed in the research as a hearer of the stories and subsequently a narrator, the voices merge and get lost. At what point is the researcher's voice distinct from the participants? And to what extent is it possible to maintain the participants' voices through the narrator telling her story?

It felt as though, from not having a voice at all, the only voice that began to come through was the author's own, almost as an over-compensation. Whilst narrative acknowledges that the listener is also the narrator, how much is it really possible to incorporate other peoples' stories in one's own? Others' stories may indeed inform our own, however considering the subjective experience of death, can we ever really write somebody else's story of death? Or tell anyone else's joke? Both humour and death are so personal, therefore is it ever possible to – and should we even pretend that we are trying to – step outside of the subjectivity? Related to this are the cautions that were raised and discussed in Chapter 2 about researching humour (e.g. Dixon, 1980), as well as the extent to which participants' answers are confined by the interview context. Not all psychological therapists that were approached agreed to be interviewed, which potentially confirms Baker's (1993) statement that "this is an area where analysts prefer privacy, as in other areas where they might attract criticism from their colleagues" (Baker, 1993:952). Having said that, the relationship between humour, terminal illness and psychological therapy remains under researched, and perhaps it is studies such as this one that can inform the thoughtful practice of other therapists. After all, each of the six participants compellingly spoke of what they had learned and whilst these cannot be extrapolated to a larger population, they are nonetheless meaningful.

One attempt to combat the difficulties of distinguishing the author's voice from participants' was firstly to present the findings as a play and further to analyse the stories with the frame of reference drawn from Aristotle's notions of Ancient Greek Theatre. Bruner's approach to narrative is one through which there is no one correct way of either displaying the research results or analysing them. Therefore, whilst the findings were grounded in narrative theory through maintaining the key components of plot, character and time, the manner in which the findings are presented is one way of preserving the distinction between the author's voice and that of the participants, and is hence an attempt to sustain the 'verisimilitude and plausibility' of the research. Further, in straying authentic to Bruner's key tenets and at the same time presenting the findings and conducting analysis in a new way could be seen as a methodological advancement of Bruner's work.

This raises the further question of what else has been missed with the research having been conducted in this way. With humour and death being so personal, what could have been learned if the research had not been conducted from a narrative perspective? Using another method such as discourse analysis for instance, could potentially have revealed more than this study has, societal and cultural influences on the therapists' experiences of humour in their palliative care settings. This feels particularly pertinent considering the participants' claims of the assumptions placed upon them as therapists by society regarding the nature of humour, palliative work, and the social constraints faced by those diagnosed with terminal illnesses.

Further, a method such as discourse analysis could consider in a different way one key aspect that has potentially not been given enough consideration here: the reification of humour. Both previous literature and the participants of this study speak of 'using' humour and it almost feels like a trap that the author has fallen into as well.

What comes to mind is the Association for Applied and Therapeutic Humour's official definition of therapeutic humour described in Chapter 1: "Therapeutic humour is any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life's situation. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual" (www.aath.org). Humour, in society today, appears to be a 'thing' to be applied as a salve or Band-Aid to make the journey to death more pleasant. To what extent, therefore, is humour being 'used' as Foucault's 'ship of fools' was? And related to this, to what extent is narrative as a method doing the same?

In considering these questions, we have on one hand Chapter 6, which indicates how humour can usurp death, take away his power, and potentially affords both therapist and patient membership of the 'collectively mad' society Becker (1973) speaks of. This is most apparent if we look at the 'causality' inferred by participants. For instance, participants spoke of a better therapeutic relationship resulting in the easier application of humour; their experience of working in palliative care settings allowing them to feel more comfortable with the presence of humour; the nature of a terminal diagnosis taking humour away from the client; and so on. Thinking about humour as 'causal' has the flavour of "the logical-scientific heritage of the natural sciences aiming to fulfil the ideal of a formal system of prediction" (Elliott, 2005:98), which the author was trying hard to avoid through using narrative. The saving grace perhaps, is that the 'causalities' that participants speak of appear to remain rooted in the particular context of the story being told and perhaps establish a means through which actions, emotions and motives can be interpreted. Looking at the 'causality'

inferred in participants' stories then, should be done tentatively in attempt to apply the ideal 'necessity and verisimilitude' called for by Bruner. Further, given what participants have spoken of, perhaps it is crucial that humour takes the role of a healthy defence mechanism, allowing access to that which might otherwise be unbearable.

Overall, telling the story as it has been in this thesis portrays the subjective experience the researcher had of being an audience to participants' stories. This maintained the requirement for valid research to have the sensitivity to context, commitment, rigour, transparency, coherence, impact and importance that were discussed in the Method Chapter. However, the very reason that narrative lends itself as the most obvious choice of method for the topic of humour and death, with concerns of time and subjectivity, at the same time also potentially yet immediately limit the story that is told. To a certain extent, the narrative model channels too much what is heard in the stories by looking for the features of plot, character, contextuality and so on. Setting the results out as they have been here, with stage directions and so on, could be said to be too 'directive', disallowing the reader of the thesis to get a sense of their own experience of participants' experiences. Approaching the research from this starting place hence takes away the possibility that perhaps there is no narrative to be told. Potentially then, using narrative here, just as humour has been criticised of doing, could be said to be an attempt to make sense of death, an attempt to make order out of chaos. Through the lens of looking at how narratives make sense of existence, the researcher runs the risk of superimposing a coherent story onto something where one does not exist. Perhaps creating a narrative out of that which cannot be faced is yet another denial against the unknown mess that death inhabits. After all, does it not just come down to what we will experience at the end, alone?

8.3 Future research

Telling this story as it has been told here takes away the possibility to tell a different story. There are a myriad of possibilities for future research in which a larger sample size, for instance, would provide more insight into psychological therapists' experiences, though possibly by risking the quality of the research by bolstering quantity. In considering what emerged from the findings and subsequent analysis there were four key areas that are thought to be worthy of further exploration.

The first is that this research was very much rooted in Western culture. Future research exploring concepts of humour and death in palliative counselling and psychotherapy in other cultures would not only widen the depth of experiences, but provide an avenue of thoughtful practice to therapists working either with patients from those cultures, or in palliative care settings in other countries.

The second is that the participants of this research were largely practicing from a person-centred framework, with the exception of Rupert who described himself as a cognitive behavioural therapist. Future research exploring the differences of the experiences of humour from the perspective of other theoretical practices would explore what space did not permit here.

The third is that each of the participants spoke of the differences in their experience of humour that the length of being a therapist in a palliative care setting gave them. Future research comparing the experiences of 'new' therapists in this field to 'seasoned' therapists would potentially inform the training of therapists in not just the use of humour, but in working with terminally ill clients.

Lastly, the stories told here are of therapists telling clients' stories. Research could be conducted in terminal clients'/patients' experiences of humour in therapy to see how these experiences might compare to those of therapists. This would perhaps

provide a therapist working in such a setting with insight as to what might be expected when humour is present.

Chapter 9: Conclusion

“I don’t want to achieve immortality through my work, I want to achieve it through not dying”

- Allen (1993:259)

The story told here is one in which a researcher embarks on a journey to explore how other psychological therapists experience humour when working with terminally ill clients. She has shifting roles between researcher, audience, narrator and author. Her hamartia is potentially her propensity to cover up negative emotions with positive ones, and her reversal of fortune occurs when she realises how much of this thesis is about her. The contending forces she thus struggles with include the need to accept and acknowledge her voice, and at the same time allow for others’ voices to emerge. The death (of the journey), and the revelation and recognition, come for her here, in this final chapter.

The story told here is also one of six psychological therapists, each of whom go on their own individual but interconnected journeys, from never having worked in palliative care settings and being wary of the seriousness that this work inhabits, to allowing themselves some freedom and accepting humour as having a presence in therapy – a presence that is potentially helpful but potentially also harmful.

The story told here is also one of a PsychD thesis, in which chapters of empirical research attempt to examine phenomena which are perhaps only possible to keep in the confines of a particular time and place. The thesis begins with a statement from the researcher questioning authenticity, but to what extent can this research be deemed authentic? Whilst ‘authenticity’ is a topic that could occupy another doctoral thesis, perhaps this is worthy of some brief consideration.

On one hand, the ‘verisimilitude and plausibility’ supported so strongly by Bruner has been maintained as much as possible through not only a prologue that elucidates the researcher’s starting block, but also presenting the findings in a manner which captures the essence of what participants were saying, and also allows the reader to ascertain some of the researcher’s subjective experience of being an audience of that story and conveying the atmosphere in the room during the interviews. However, to what extent is the style of narrative used here too directive and disallows space for another subject, the reader, to interpret it differently? That being said, the reader was not present at the interviews, and what has been offered here is a conveyance of what was experienced, which can only ever be subjective to the one that experiences.

Further, a key aspect of narrative research is ‘truth’ and ‘fiction’. Whilst an attempt has been made here to avoid presenting an ultimate ‘truth’, it has also tried to maintain the ‘truths’ of the participants. However, to what extent is research ever true? Can it be more than just another story? To that end, is the use of humour, either as an individual or as therapists working with terminally ill clients ‘true’? Or is it a way of falsely covering up what is difficult to bear? Alternatively, does humour help access a ‘truth’ that is otherwise too difficult to speak of?

What emerges from this study is that the relationship between humour, terminal illness and psychological therapy is complicated, powerful and visceral. Humour, and indeed death are fundamental to us as human beings; laughter, after crying, is one of the first things we do with the world to engage with it as a human being. Other than the physiological needs of safety, warmth and nourishment, our propensity to look for humour and find something funny is almost what makes us human, and similarly, as the participants of this study so eloquently portrayed, we are

never more human than when we are dying. Thus, what is appropriate and what is not when it comes to humour with the terminally ill client in therapy almost becomes irrelevant when humour is a means by which we hang on to our humanity in one last attempt to engage with the world before we leave it.

Postscript

What now of Gauri's story? I began this research process, first from a place of misgiving and doubt regarding humour, to then being absorbed by the enormity of literature supporting the relevance of humour in palliative care. Re-reading this thesis several months after completion, I am struck by how I have been blinded by my own 'use' of 'humour' throughout my life, the extent to which both 'terminal illness' and 'humour' are potentially signifiers or metaphors for something other than just the dictionary definition of these terms, and the manner in which this thesis potentially speaks to the nature and purpose of therapy. It is perhaps then not surprising that my own personal therapy lately has been much deeper and much more meaningful than I have ever let it be.

At times it feels as though humour has hindered me from doing all the things the literature review claims it helps with – meeting resistances, for example. Am I employing humour as a decoy? A deflection? Has humour provided for me, what is referred to on page 34 as 'a momentary anaesthesia of the heart'? Or have I been laughing at myself to avoid analysing conflicts – to 'avert madness' (p. 45)? I also refer to research which claims that humour 'awakens peoples' disillusionment', but to what extent have I disillusioned myself through humour? Has humour been my opiate? Related to this is potentially the question of the purpose of my research – have I just wanted to provide an answer that in some way confirms that it is indeed okay to maintain my happy façade and not confront my horrors? Did I want participants' quotes to corroborate this 'assertion and rebellion against [my] own helplessness' (p. 37)?

There is no doubt that this research has interrupted a certain complacency within me, forcing me to look at how I am in this world, how I relate to others, how I feel about my own finitude, and how I derive meaning. By so doing, in some ways it has confirmed my pre-established views, but has also opened up contradictions. This, I think, is a poignant reflection of Bruner's claim that the nature of language in telling stories both reveals and constricts. The same can be said of humour.

Appendices

Appendix 1: Ethical Approval

The research for this project was submitted for ethics consideration under the reference PSYC 14/ 133 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 07.07.14.

Appendix 2: Invitation Letter



INVITATION TO PARTICIPATE

Dear

I am looking for participants to interview for my doctoral research with the University of Roehampton. I am exploring psychological therapists' experiences of humour in sessions with clients diagnosed with a terminal illness.

I thought that the following information would be helpful to you when making your decision regarding participation:

Purpose of the study:

This is a qualitative research inquiry that aims to explore '*the experience of humour in sessions with clients diagnosed with a terminal illness*' and I intend to recruit 6 - 8 participants for this study.

Expectation of participants:

You will be invited to participate in an audio-recorded interview lasting approximately 60 minutes. The interview will take place at an appropriate location convenient for you. This semi-structured interview will focus on your experience of humour in sessions with terminally ill clients.

Confidentiality:

If you agree to take part in the study you will be required to sign the attached consent form indicating approval to the recording of the interview and participation in the research.

All your personal details will be anonymised and you, the clients you discuss and your organisation, will not be personally identifiable. I will also respect confidentiality and will ensure that information or data collected about individuals are appropriately anonymised and cannot be traced back to them by other parties, even if the participants themselves are not troubled by a potential loss of confidentiality. All collected data will be securely stored at all times and kept for a maximum of ten years for the purpose of publication.

Although you will be asked to draw on your experiences of working as a therapist with clients with terminal illness, you will be asked not to reveal any confidential or identifying details about your clients/patients.

Right to withdraw:

All participation is voluntary. Should you wish to withdraw from the study, you are free to do so at any time (however, as it may not be possible to remove data from a written up-report, some data may still be used in a collated form).

Findings and publication:

You may request from me a summary of the study's findings by providing your contact details. The findings of the research project may be published in journals but anonymity and confidentiality will be upheld at all times.

Reimbursement:

Unfortunately, no costs related to the participation will be reimbursed.

Risks:

You are entitled to decline to answer any interview question and may take short breaks during the interview process if required. To ensure the safeguarding of your well-being, both you and I, reserve the right to terminate the interview at any point should you become excessively distressed during the interview.

Should you experience unwanted distress as a result of participation you may refer to contact details for help-lines and therapeutic services which will be supplied in the debrief information sheet.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies:

Professor Del Loewenthal
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London
SW15 4JD
d.loewenthal@roehampton.ac.uk
0208 392 3615

Head of Department:

Dr Diane Bray
Department of Psychology
Whitelands College
University of Roehampton
Holybourne Avenue
London
SW15 4JD
d.bray@roehampton.ac.uk
0208 392 3500

Yours sincerely

Gauri Chauhan

Department of Psychology
Email: Chauhang11@roehampton.ac.uk
Tel: 07837 205 318

Appendix 3: Risk Assessment



Ethics Risk Assessment

RISK ASSESSMENT FORM			
Description of activity	Interviewing participants	Date	11/06/2014
Area/Locations	Offsite offices/rooms		
Risk assessment team	Name	Job Title	Signed
	Gauri Chauhan	Doctoral student	
	Prof Del Loewenthal	Director of Studies	
Hazards	<ol style="list-style-type: none"> 1. Emotional distress 2. Discomfort at being audio recorded 3. Lone worker safety at interviews 4. Travelling to and from interviews 5. Electrical equipment/recording equipment/tripping on cables 6. Confidentiality/anonymity 7. Data storage 		
Who can be harmed?	Participant and researcher		
How can someone be harmed?	<ol style="list-style-type: none"> 1. Content brought up in the interviews may cause distress to both parties 2. Participants may feel discomfort at being audio recorded 3. The researcher is at risk of danger when lone-working, particularly if travelling to an unknown location with people not previously known to the researcher 4. Travelling to and from interviews may be dangerous in the event of a car accident or breakdown, for instance 5. Either participant or researcher may trip on cables that may be attached to audio-recording equipment, or any bags that may be in the area 6. Confidential information will be discussed at the interview 7. Confidential information will be recorded at the interview 		
Number of people affected	2	Rate	H=Hourly, D=Daily, W=Weekly, M=Monthly, Q=Quarterly, S=Six monthly, A=Annually
		H	
Consequence	<ol style="list-style-type: none"> 1. The participant or researcher might find it difficult to continue the interview 		

	<ol style="list-style-type: none"> 2. The participant may show signs of discomfort with the prospect of being audio recorded and thus find it difficult to continue the interview 3. The researcher or participant may get lost or find themselves in an unsafe location, where their personal safety may be threatened 4. The researcher or participant may have an accident travelling to the interview, or break down. 5. The researcher or participant may trip on any items on the floor and hurt themselves as they fall 6. The information discussed is confidential in nature and requires anonymity so that it is not mishandled by someone not involved in the research. 7. Confidential and sensitive information will be recorded and requires security so that it is not mishandled by someone not involved in the research. 	
Existing Control Measures	<ol style="list-style-type: none"> 1. Participants are trained therapists and will be in supervision. The consent form will highlight the nature of the interview and participants will be aware that they can withdraw from the research at any stage. The researcher is in weekly personal therapy and weekly supervision and is aware from the offset of the nature of information that might arise from the interviews. 2. Participants are aware before the interview commences that they will be audio-recorded and can stop the recording if necessary. 3. The research will be carried out in an area familiar to the participant, so they are unlikely to get lost or find themselves in an unsafe location. The researcher is choosing her own participants and is therefore unlikely to choose someone that is not safe or works from an unsafe area. 4. Usual transport safety measures are followed. The researcher has insurance on her vehicle and breakdown cover. 5. The recording equipment that will be used is wireless. 6. The researcher, as a practicing therapist, is familiar in maintaining confidentiality 7. The researcher is adept and experienced at making client notes and storing them securely 	
Comments		
Bibliography		
Risk rating	M	VH=Very High, H=High, M=Medium, L=Low, VL=Very Low
Further possible control measures	<ol style="list-style-type: none"> 1. Participants will be reminded in the interview of their right to withdraw at any point during the interview. Regular breaks can be taken, and should the researcher feel distressed, she will 	

	<p>seek support from her supervisor or therapist.</p> <ol style="list-style-type: none"> 2. Regular breaks during the interview can be taken if needed, and participants will be reminded that they are free to withdraw from the study whenever they wish. 3. University of Roehampton's 'Lone Working Policy' will be adhered to by telephoning someone before and after interviews; having a contingency plans in place for what happens if no call is made after the interview, and ensuring mobile phone is charged and working. 4. Ensure usual transport safety procedures are followed. 5. Check room before interviews; remove/tidy any hazards where possible. 6. Confidential data handling; use codes for each participant's interview and disguise their clients' names. Secure storage of audio recordings and transcripts. 7. Secure storage of electronic interview transcription on a password protected computer; data backed-up on a USB stick. Any hard-copy transcripts will be kept in a locked box. 			
Any further actions required				
Responsible person	Description of hazard	Details of action taken	Date	Completed
Date to be reviewed		To be reviewed by (name)		
Signed (Applicant)	Gauri Chauhan	Print Name and Date	11/06/14	
Signed (Lead Assessor, if different from applicant)				

Appendix 4: Consent Form



Participant Code.....

PARTICIPANT CONSENT FORM

Title of Research Project:

'Stories of Comedy and Tragedy in Therapy: Psychological therapists' experiences of humour in sessions with clients diagnosed with a terminal illness'

Brief Description of Research Project:

This research project is interested in exploring the experiences of humour in sessions with clients diagnosed with a terminal illness. Interview questions will be used to ask therapists about their experiences of humour with such clients. 6 – 8 participants will be recruited.

Participants will take part in a single audio-recorded interview lasting approximately one hour. Participants will be asked if they would want to be interviewed at the university or their place of work, for convenience reasons. The interviews will be transcribed and analysed; the data will be included in the thesis.

Investigator Contact Details:

Gauri Chauhan
Psychology Department, Whitelands College, Roehampton University, Holybourne Avenue, SW15 4JD
chauhang11@roehampton.ac.uk
Tel: 07837 205 318

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point without giving a reason, although if I do so I understand that my data might still be used in a collated form. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.

Name

Signature

Date

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department or Director of Studies.

Director of Studies Contact Details:

Prof Del Loewenthal
Department of Psychology
Whitelands College
Holybourne Avenue
London
SW15 4JD
d.loewenthal@roehampton.ac.uk
+44 (0)20 8392 3615

Head of Department Contact Details:

Dr Diane Bray
Department of Psychology
Whitelands College
Holybourne Avenue
London
SW15 4JD
d.bray@roehampton.ac.uk
+44 (0)20 8392 3627

Appendix 5: Sample transcript

HERMAN

		Themes	Interaction	Continuity	Story
			Personal/social	Tense	
1	GC: As you know I am doing my research on humour and terminal	Laughter			
2	illness. I am trying to explore comedy and tragedy in psychotherapy and				
3	counselling and looking at this as a way of exploring that. I thought that				
4	we could start by you telling me a little bit about your practice, your				
5	experience of working with patients/clients with terminal illness, and				
6	then maybe more specifically about your experience of humour in				
7	interactions with such clients.				
8	HERMAN: So I've got to do all the work, you you've got no				
9	questions [laughs].				
10	GC: No questions, I will be asking questions as we go along – if				
11	there's something that piques my interest, I'll go 'oh, how about that?'				
12	I'm not planning on taking notes or anything.				
13	HERMAN: That's fine. Right so, I mean I'll talk about the relevant	Previous experience	1st Personal	Present	Plot
14	stuff, I get involved in lots of different areas around HIV, around private		Active		Situation
15	practice and all sorts of things but the thing you're probably most		2 nd		
16	interested in is working with, as you say, working with terminal illness.				
17	I've worked with um [redacted] um for 5 years, the last 2 years	Current experience	1 st	Present	Temporality
18	I've been working with terminal illness, I've had four clients, um who				Character
19	have all been terminally ill. Currently I have one client um just about to		1 st	Present	
20	pass away, die, um, the last time I saw him was probably about 3 or 4			Past	Temporality
21	weeks ago. I have another client who's got Motor Neurones, very rapid,		1 st		Character
22	very aggressive, you know it's been very, very quick actually for him,				
23	that I've probably been seeing for the last 8 months and saw him this			Past	Temporality
24	morning and he's doing well but he's not doing well if that makes		3 rd		Contradiction
25	sense, you know um. I've also worked a little bit with, most of my				
26	work's been with bereavement work, so with partners of people		Social		Situation
27	who've died or other family members. I've also done a couple of pre-		1st	Past	
28	bereavement um er. I've had a couple of pre-bereavement clients, so				

29	working with clients				
30	GC: Who are carers maybe				
31	HERMAN: Yeah, where their partners have then died. Ok, um, I		5 th	Past	Situation
32	think probably the most pertinent part is in that, you know, working	Working with TI clients	2 nd	Present	Situation
33	with the terminal you see how people actually how people live with	Living with dying	5 th		Contradiction
34	their illness, with the fact that they are dying and that acceptance and		Social		
35	understanding and how they deal with it.				
36	GC: Sort of being confronted by it almost				
37	HERMAN: Absolutely, absolutely. For a lot of it, for a lot of people	Working with TI clients	5 th social	Present	Causality
38	it's very hard and it all comes out in so many different ways, you know	Living with dying	passive		
39	it's part of that protection mechanism of saying, 'oh it's not as bad as	Protection mechanism			
40	all that really, is it?' you know so it's the whole defence thing that	Defence			
41	comes through. There's also the, um, 'I need to cheer myself up, just in		1 st		
42	the moment, you know and make it just feel slightly better than	Making it better than it is			
43	perhaps it was.' For some I think it's a really good observation on life.		1 st		
44	GC: An observation on life.				
45	HERMAN: Yeah, I think it's their take. They've got to a point		1 st 5 th	Past	Causality
46	where they say, 'actually, I've got nothing to lose by saying what I want	Openness	1 st	Present	
47	to say, you know, and if I can take the <u>mikey</u> or say something that's				Metaphor
48	maybe kind of irreverent, great, I'll do it. I'll, I, I've almost got the, it's a				
49	bit like you would, you reach a certain age in life, you know and you		2 nd		Temporality
50	suddenly say 'I can say whatever I like because I I've earned the right to	Freedom	1 st	Present	
51	do it.' You know, um, and <u>and</u> I think, I think there's something very, for				
52	me it feels quite self-caring in a way because	Self-caring			
53	GC: To be humorous				
54	HERMAN: Yeah, yeah because it's very <u>easy</u> . I've got personal	Personal experience	1 st personal	Present	Situation
55	experience as well, like my father died when [REDACTED]			Past	Character
56	[REDACTED], he died and obviously				Temporality
57	going through the training and everything else, that's sort of part of it				
58	and <u>um um</u> he was very humorous and used a lot of humour, you know		3 rd	past	

59	and and we used humour with him as well, I think it's this isn't just		4 th 1 st	Present	Character
60	about the client's humour it's about the therapist's humour you know	Clients and therapist's humour	Social		
61	and it's about you know there's this two way street there and things	Allowing something			Metaphor
62	and it allows, really allows, that connection and understanding to say,	Connection			Situation
63	'you know what, it's <i>ok</i> , you know, to <i>be</i> like this. It's <i>ok</i> to say, you	Understanding	2 nd		Causality
64	know, something rude, something naughty, something	Allowance			
65	GC: It's ok to laugh about it				
66	HERMAN: Yeah, absolutely. Absolutely. Yeah, and took me a	Early experiences of humour with TI client	1 st	Past	Temporality
67	while, if I'm going to be really honest I think the first, with the first				
68	client that I had that was terminally ill, I think there was a real need for	Guarded	passive	Past	Situation
69	me to be absolutely guarded, you know, not say anything that might be	Belittling			Metaphor
70	offensive, not to try and belittle what that person's situation was, make	Discomfort			
71	light of it or anything like that, so for me to be humorous felt very		1 st		
72	uncomfortable				
73	GC: So it felt by being humorous you were sort of belittling what				
74	they had to bring				
75	HERMAN: Yeah, yeah, it, almost it, then it sort of seemed to feel	Undermining seriousness			Plot
76	to me that I was somehow undermining the seriousness of what they		1 st	Past	
F77	were going through, you know. And I think that particular client came				Character
78	out with two or three comments over a period of, you know, over a	Therapist's response			
79	number of weeks, and made me come away with thinking 'how shall I	Therapist's laughter			
80	have responded?' you know, and I wanted to laugh because it was	Guilt at humour	Personal		Causality
81	humorous and I felt guilty for wanting to laugh because there's almost	Laughing with rather than at			Contradiction
82	that sort of, that sense of 'I'm laughing at your situation rather than	Boundary			
83	laughing at what we're talking about'. It's very hard to sort of have that	Keeping it separate	2 nd	Present	Situation
84	boundary in place where, where you can keep the two separate.				
85	GC: And then knowing when the sort of laugh with them or just be				
86	there				
87	HERMAN: Absolutely, it's that poe faced I don't know if that's	Psychoanalysis	Passive	Present	Metaphor
88	psychodynamic or psychoanalytic, 'well now, mmhmm ' [laughs]	Laughter			

89	GC: [laughs] 'what's that really about?'				
90	HERMAN: Absolutely, you know and actually I think terminal,	Counselling TI patients	1 st	Present	Situation
91	terminal support is very <u>very</u> different from other types of therapy if		personal		
92	I'm really honest. I think it's not you know, whether it's bereavement or				
93	any, any, any of the other things that we might be dealing with,	Difference of counselling TI patients	4 th	Future	Plot
94	addiction what have you, um, we're looking to <u>improve um</u> the client's		social		Temporality
95	understanding of himself, you know, their ability to live with		3 rd		Causality
96	themselves, make the appropriate decisions for themselves and afford	Reaching an end TI patients are happy	5 th		
97	a better quality of life, you know, that they can embrace, much more	with		Present	Implied
98	wholly. Um, it's not like that with <u>terminal clients</u> or terminal patients.		1 st	Future	
99	It it's how to, for me, it's about how to allow them to reach an end that	Doing what the client needs			
100	they feel happy with, you know and that's	Counselling patients with TI			
101	GC: The best end possible	Can't make it better		Present	Plot
102	HERMAN: Absolutely and it's about, it's actually about doing	Denial	2 nd		
103	whatever the client needs to do. You're not trying to make it better	Awareness	5th Active	Future	Character
104	because you bloody well can't. Client's <u>gonna</u> die. They know they're	Can't make it better		Present	
105	<u>gonna</u> die. They might be in denial that that [some of them will but	Can't 'fix'	1 st		Plot
106	actually then another?] they always very <u>very</u> aware of what that		4 th		
107	means, you know, and I can't make it better. I can't even pretend that				
108	we can try and quote unquote fix, not that we do that in therapy,				
109	well...do you know what I mean?				
110	GC: I know what you mean, I find having worked with terminal				
111	patients as well that it's mostly just about staying in the despair and				
112	<u>kinda</u> knowing that it's not <u>gonna</u> be fixed, whereas it sometimes feels				
113	that although we don't do that in therapy with other patients, or				
114	clients, there might be the hope that it could be fixed, whereas here it's	Lack of hope			
115	just about staying in that space.				
116	HERMAN: And that's the difficulty, it's the lack of hope, it's the	Living a full life	3 rd passive	Present	Plot
117	lack of hope that you have in terms of someone being able to go on and	Working with TI	2 nd		Temporality
118	<u>leave a</u> full life, because you know, that always comes from our own		4 th		

119	reference point. A full life for me is hopefully another 10, 20, 30, 40		1st Personal		Situation
120	years, you know that isn't the way for the client, so you know, with	Lack of longevity	social		Temporality
121	terminally ill patient, they may have 6 months or whatever it may be,	Allowing them to be how they need to be	5 th		
122	um so that <u>longevity</u> just isn't there, so it, you know, it's about	Unknown something	passive		Causality
123	allowing them, for me it's about allowing them just to be how they	Not closure	1 st 5 th	Present	
124	need to be, you know, um, so that they get a sense of something, what	Freedom of speech	social		Unknown
125	that something is I can't tell you. You know, it's not about closure	Allowance/freedom	1st personal		Metaphor
126	necessarily, it might be just being able to say what they wanted to say,		5 th	Past	Situation
127	just being able to spill something that they haven't been able to spill,				Metaphor
128	you know it might just be having a friendly voice at the end of, you				
129	know, someone who understands and doesn't judge when they say				Situation
130	<u>something that they can't say to anyone else.</u>			Present	
131	GC: Or just sort of unburdening so that, you know, because				
132	sometimes they feel they worrying their carers or partners or whatever,				
133	it's nice for them to just have the space to be able to do it without				
134	having to worry about that.	Laughter			
135	HERMAN: Very much so. Don't know where I'm <u>gonna</u> go now.			Future	Metaphor
136	<u>[laughs]</u>				Break
137	GC: You were sort of talking about the differences between clients				
138	with terminal illnesses compared to sort of the others that you expect				
139	to live a full life after we've worked through whatever we're working				
140	through. Do you think there's a difference between the <u>use</u> of humour				
141	with both of them as well? The humour that's in the room, so not				
142	necessarily the client's humour but maybe your humour too and the				
143	way that that works.				
144	HERMAN: I think personally, the only difference that strikes me	Encouraging humour with non TI patients	1 st	Present	Metaphor
145	immediately is that working with clients who aren't terminally ill, I	Importance of humour	Personal		Causality
146	encourage humour, I like obviously I've got bits and pieces that allow a	Establishing relationship	Active		
146	bit of fun to come in, um and I think humour <u>is always</u> really important.	Early sessions challenging			
147	Once, I think once the relationship is established I think humour in the	Building trust	1 st		Temporality

148	early days can be quite challenging because you don't really get the	Understanding each other	2 nd		
149	other person just yet, you know, I think once you've got that trust and		1 st 2 nd		Situation
150	you know, that you understand each other, I think it works really well.		2 nd 1 st		
151	GC: It's quite an individual thing in that respect				
152	HERMAN: Absolutely, yeah. Um. Interestingly I think just thinking	TI clients use humour earlier	1 st	Present	Temporality
153	back I think that's true with clients who are terminally ill. I think with				
154	clients who are terminally ill, they use humour much earlier. You know	Clients waiting for reaction			Situation
155	it comes in the very first session sometimes and they make some sort	Comfort with experience	5 th		
156	of glib comment and I know they're waiting for a reaction. I'm much	Early session panic	1 st		Temporality
157	more comfortable with that now having worked with a number of		personal		Plot
158	people but um I, I do remember the panic that I was thrown into in that	Disrespectful humour		Past	
159	first few occasions, like 'what on earth do I say here?' you know,				Causality
160	because whatever I say isn't gonna feel right. It feels, it feels			Present	
161	disrespectful.				
162	GC: So disrespectful in the sense that either you're belittling it or				
163	not responding to the humour, in which case that's disrespectful as				
164	well?	Needing supervision			
165	HERMAN: Yeah, it's very hard holding those two. And I, it was one		1 st	Present	Metaphor
166	of those things I just had to take to supervision because what the hell			Past	Plot
167	do I do?	Dealing with humour: Blank canvas	1 st	Present	Situation
168	GC: What did you find yourself doing?	Discomfort			
169	HERMAN: Um, keeping a blank canvas, you know, and feeling very	Missing something	1 st	Present	Metaphor
170	uncomfortable in that process knowing that I'd missed something, you	Disallowing	personal	Past	Causality
171	know knowing that I'd missed something that could have been really	Closed off	passive		Situation
172	really embracing and holding for the client, um and recognising that				Implied
173	perhaps it disallowed them from engaging with their own state, their		personal		
174	own way of being because I felt so closed off, I wasn't able to respond,	Expectation of humour to be present	5 th	Past	Plot
175	so I'm sure that may have added to the, certainly to that client's. I think		1 st		Character
176	the other clients I now, having worked through that first client, you			past	Temporality
177	know with the other clients, it almost became an expectation		Passive	past/future	

178	GC: That they'd be humorous				
179	HERMAN: Yeah, or that humour could be there, you know, in that	Confronting it	3 rd passive	future	Implied
180	way.	Not avoiding			
181	GC: So you feel more able to sort of respond to it now than you				
182	used to	Others' discomfort			
183	HERMAN: Absolutely. And I'll name it for what it is, you know,	Culture	1 st active	future	Metaphor
184	rather than trying to avoid it. It's that whole thing of death and	Getting passed personal boundary			Situation
185	humour, you know, black humour and all the rest of it. I mean, it can be		3 rd	present	
186	uncomfortable for a lot of people and culturally it can be very difficult	Different in personal life and with client		present	Causality
187	as well. I think once you get passed that , once I could get passed my		1st personal		
188	personal boundary, I mean I've laughed in loads of situations that are	Boundaries	1 st social	past	Temporality
189	very black, you know at funerals and what have you, um, and that's fine			present	Metaphor
190	because that was about me, you know, it doesn't translate quite so		personal		
191	easily when you're with a client, you know, because it's about the		2 nd		
192	client. It's constantly being aware of those boundaries and sort of trying		passive	present	Metaphor
193	to hold them				
194	GC: And so you feel a bit more relaxed with humour when it's in the	Therapist initiating humour			
195	room now with those clients and able to respond to it and joke as well				
196	or do you sort of leave it up to the client, do you ever kind of bring	Referring back with humour			
197	humour into it?				
198	HERMAN: I do, I do if something, and it might be something that's		1 st	Present	Causality
199	sort of um the client might have said two three weeks ago, you know		2 nd		Temporality
200	that might sort of, or just refer back to as a sort of humorous	Humour relaxes			
201	counterpoint to what they are saying now and quite, more often than	Treating TI clients like a person	5 th	Present	
202	not, clients will get that because I think they remember their comments		1 st		
203	and what have you. It's quite funny actually, you see clients when if I	Personal			Plot
204	introduce humour you can see them relax a little bit more because I'm		1st		Causality
205	treating them like a person not like a dying person.	Humour's importance			
206	GC: So it's making it a bit more personable	Easy			
207	HERMAN: Yeah, yeah and actually for me the thing about humour	First confrontation with humour	1 st		

208	is it goes past the situation and touches the person, you know because	Therapist getting wrapped up	3 rd	Present	
209	humour is a very important part of all our lives, you know and it's so	Increasingly genuine			
210	easy, you know it's, I, I can think I got very anal in that with that first				
211	client about, you know, got wrapped up in the situation I think, you	Congruence	1 st	Past	Temporality
212	know, the devastating situation that client was in, you know with their				
213	life passing away, passing by. And um now it feels more genuine?	Bereavement			
214	GC: A bit more real?				
215	HERMAN: I can be me. <u>And that</u> also I think helps the client to be	Presence of humour	1 st	Present	Plot
216	them. You know...and actually comes out, it's sort of transferred into				
217	bereavement work as well, you know just with, you know working with	Permission	<u>passive</u>		Metaphor
218	people who have lost their husbands or wives or what have you and	Rounded			
219	you know there are humorous stories told, there are sort of humorous	Whole			
220	references, there are funny little anecdotes or feelings or observations,	Personal and professional humour			Causality
221	you know and um it's helped me, it has helped me allow that to happen		1 st	Past	Situation
222	much more and a more rounded approach. And there is something				
223	about being with a client wholly, rather than sort of saying you know,			Present	
224	'this is my professional hat and this is my personal hat' personal is	<u>Holistic</u>			Plot
225	humorous and professional isn't.				Causality
226	GC: It feels like more of an amalgamation of the two, you can fully				
227	be yourself				
228	HERMAN: Absolutely, and previously because very holistic sort of	Connection			
229	approach I think.				
230	GC: So being able to feel freer in using humour in your sessions				
231	make you feel like it's more you	Genuineness			
232	HERMAN: More connected	Allowing for something			
233	GC: And it's the humour that makes that happen	Permission			
234	HERMAN: Yeah, it's <u>it's</u> <u>it's</u> like anything. I mean, <u>if</u> <u>if</u> we were	Fear of humour	4 th	Present	
235	making it with anyone, if we hold part of ourselves back, are we really	Belittling/insulting			
236	being ourselves? You know so it's allowing all of that to come through	Disrespectful			
237	and I think for me, I needed to get to a point where I had permission to	Building something stronger	1st	Past	

238	allow that to happen, and a lot of that for me was the fear, I think, of as	Allowed the client	1st	Past	
239	I say belittling or insulting or really somehow, you know, the client	Humour allowing access to pain			
240	feeling disrespected by by the humour I used. Um, actually that's not				
241	been my experience. My experience is it's built something much	Clients test therapists		Present	Causality
242	stronger you know and it's allowed, actually I can think of two or three			Past	Causality
243	key situations where it's that humour has allowed the client to touch				
244	something very raw, very painful				
245	GC: It's helped them sort of access it.	Exploring vulnerability			
246	HERMAN: Yes and may, sometimes humour is used as a testing		3rd plural	Present	Plot?
247	bed, isn't it, you know where the client will say something humorous			Future	Metaphor
248	just to sort of gage you know that reaction before they can actually				Causality
249	really explore their own vulnerability of feeling what it might be.				
250	GC: So in that sense maybe humour allows them to be fully				
251	themselves as well				
252	HERMAN: Absolutely. Yeah, very much so.				
253	GC: So your experience I guess in the situation you're thinking of	Humour as distancing/avoiding			
254	has actually helped clients to deeper access something rather than	Early stages of therapy			
255	maybe using it as a distancing technique or kinda laughing it off, instead	Distancing			
256	of that you think it's helped you access something much deeper	Testing waters	3 rd plural		Causality
257	HERMAN: Well in some cases, in some cases. I think for a lot of	Acceptance		Present	
258	clients, they do use humour to distance it's a way making it not real,	Therapist/client relationship	1 st		Temporality
259	you know um I think quite often that happens in the early stages of	Not all doom and gloom	passive		Metaphor
260	your engagement with therapy, there's the distancing happens, you	Honesty through humour		Present	
261	know, and again it's about testing the waters as well, it's 'I can joke				Causality
262	about this and you can accept that and if you can joke about it and I can				
263	accept that then maybe there's something that we can do that's, you	Early sessions			
264	know, that's positive here.' It doesn't have to be all doom and gloom	Humour testing			
265	and distress, you know, and it does allow a much more honest appraisal			Present	
266	of what might be going on for the client and the therapist, you know.	Therapist/client relationship			
267	But in the early days, initially, I think it's always, there is always that	Permission	1 st		

268	testing, I've not thought about it before, but just reflecting back there is	Individual experiences	1 st	Present	Temporality
269	always that sort of testing the water and seeing how this is going to				Metaphor
270	work. You know and also, and also it's about, I think both therapist and			Present	Situation
271	client saying 'is it ok to be like this with the two of us here?' you know,				
272	just to have, just because I've worked with one client, that maybe a lot			Past	Grammar
273	of humour, doesn't mean to say that that would happen with the next			Future	
274	client.	Distressing sessions			
275	GC: No and I guess the client as well, from session to session, some				
276	sessions might be ok to use a bit of humour and others might not.	No humour in distressing sessions			
277	HERMAN: Yeah, and I often have, I mean if I have a very			Present	
278	distressing session, I'm thinking about the guy I saw today, um three				
279	weeks ago I had actually really quite a, quite a tough session he had,	Humour making things bearable	1 st	Past	Grammar
280	you know um, and there was very little humour in there, there was no				Temporality
281	humour in that session at all to be honest, you know and next time I				
282	saw him, you know his immediate response was 'God, I was a right prat				
283	last week wasn't I?' You know, and he sort of recognising where he was				Situation
284	at but being able to say it in a way that made it ok. But also, also made			Present	
285	it bearable by being humorous.			Past	
286	GC: So there's the sense that the pain almost, the despair comes a				
287	bit more bearable				
288	HERMAN: Yeah, yeah.				
289	GC: Good. I can't think of anything else to ask really. I guess what I	Spontaneous humour			
290	should have asked maybe before the interview was whether you had				
291	any deathly jokes or any sort of black humour as a way of making it fun	Jokes vs. humour – rooted in reality and			
292	HERMAN: I can say that I don't, I love black humour but a lot of	personal experience	1 st	Present	Metaphor
293	it's spontaneous rather than sort of the preconceived idea you know,				Situation
294	and often I just thinking about clients, you know it is[n't?] like a 'boom			Present	
295	boom', it is, it isn't that sort of jokey humour that's coming through, it's	Relationship			
296	very, very, very very much rooted in reality and personal experience				Metaphor
297	GC: So that kind of makes it spontaneous then	Allows client to be themselves			

298	HERMAN: Absolutely and it is that spontaneity. For me I think my	Outcome of using humour	1 st	Present	Situation
299	stance on it is it all being about relationship, it's you know, if I can be in	Effect on therapist			Causality
300	a relationship with a client and hold them, hold them in a way that				Metaphor
301	allows them to be them, um then something good happens. I don't, I				
302	often don't understand what or why um but something good always	Current experience			
303	seems to happen, actually for the both of us. Um I don't, that does				
304	come from a spontaneous place of being I think, rather than the	Transference			Situation
305	[inaudible]. I'm just considering in fact, and actually it's the client I'm				
306	working with at the moment, who who I actually, um, so much				Situation
307	transference that goes on because he's a similar age to me and you		3 rd		
308	know and very similar sorts of backgrounds and what have you and he's				
309	the sort of guy that I might have had as a friend outside of this				Situation
310	therapeutic relationship you know if circumstances would be right, and				
311	he is the sort of person that I would very easily joke with and I think he	Clients losing humour in illness		Past	
312	does have that sort of wry smile you know, where he looks at life and			Present	
313	how things are in life, um where was I going with this? [Pause] see, I	Importance of humour			Break
314	sidetracked myself there, yeah, yeah , I think, I think he's the sort of	Regaining a loss through humour			
315	person that might have had jokes or say jokes, but I think in, in a well			Past	Situation
316	time he would be, I think that's part of what he's lost, which is one				Causality
317	another reason why humour's really really important because he, he, it			Present	
318	allows him, it gives him a um an avenue of a way of expressing				
319	something that has stopped for him, you know I know because I ↓				
320	actually counsel him at home because he's immobile, I know and			Present	Situation
321	having spoken to his wife obviously and his kids just in passing that	Clients use of humour outside of therapy		Past	
322	they'll often make comments as I come in or come out you know and			Future	
323	they've sort of alluded to um his relationships with peers, with work			Past	
324	peers and what have you and how he's always been the joking one and				
325	what have you, but I don't think he can do that or be that anymore, you			Present	Causality
326	know, so he has to use humour in a different way I think	Humour allowing access			
327	GC: In what sort of way do you think he uses it?	Previous experience			

328	HERMAN: Um, I think rather than I think he would see it as humour, but	Irreverent humour	1 st	Future	Causality
329	I think [pause], I think he uses it in a way of of being able to, just to	Taking the mickey	3 rd	Present	
330	touch base with his own feelings, you know rather than something, and	Insulting humour			
331	I suppose that's where my confusion when I you know, with the first	Current experience			Temporality
332	client I had about this sort of irreverence that comes through with	Humour as accepting/understanding		Past	
333	humour saying something that takes the mickey out of someone, you	Normalising through humour			
334	know could be quite insulting and that's part of what humour				
335	incorporates, and I think that's how he would have been whereas now,	Changing experience through humour		Future	Temporality
336	it's not about insulting, it's more about accepting and understanding				
337	and normalising, actually it is about normalising more than anything			Present	
338	and being able to say, you know, this isn't good, but it's normal, you				Causality
339	know so it allows him to experience it in a slightly different way. I was			Future	
340	gonna say we had a conversation not so long ago where some work			Past	
341	colleagues came over and he did say because he was a joker at the			Past	Plot
342	office and he told me that and family and he said that he had his work				Situation
343	colleagues and he said 'the thing is' he said 'they come in, it's all like,	Others' experiences of humour and death		Past/Present	
345	it's like they're at my funeral.' He said 'they all come in with long faces	Client's experience of humour outside of			Metaphor
346	and everything else, 'oh, oh, isn't this awful' and he said, 'the looks on	therapy			
347	our faces when I say something, you know, crack a joke and say 'how's				
348	fatso so and so doing' or what have you and and they are taken aback				Causality
349	because there's that expectation of humour brings that we often have,		4 th		
350	of 'this is serious and we can't be funny'	Effect of TI			
351	GC: And they must have changed now that they've had their diagnosis,				
352	they're not gonna be the same jokey person, surely not	Others' reaction to TI diagnosis			
353	HERMAN: Absolutely, the whole persona has changed and everything	Importance of therapy for TI	1 st	Present	
354	else, so, and I think, and from what I understand from what he was	Permission to be genuine			Causality
355	saying is that they still find it quite difficult to engage at that level as				
356	they would have done before, which is maybe where the therapy helps,				
357	because it allows you to do that you know and actually just be		2 nd		Situation
358	themselves in a way that maybe other people deny that opportunity			Present	Plot

359	GC: And I guess with patients with really severe terminal illness that	Current experience			
360	have lost maybe a lot of their bodily functions, or whatever, sometimes				
361	the conversations I've had with clients is that it's a lot about the loss				
362	and sometimes they've lost so much but actually they've still got their				
363	humour and that's something that they can very much still be present				
364	HERMAN: But I think, there's something about giving permission	Client's humour outside of therapy	1 st	Future?	Causality
365	though. You know um, I think humour, certainly for, you know looking			Present	
366	at, I'm referring to this guy quite a lot because I think he's the one			Past	
367	where I've had the most humorous relationship in a way, also it's				
368	where I've been in the family unit at home so it <u>sorta</u> becomes more	Therapy give client permission to be		Present	Situation
369	apparent that humour in the family home doesn't exist, it all feels very	humorous			
370	heavy, very serious, you know, lots of anger, lots of despair, lots of um				
371	you know, pre-empted loss feelings, all of that seems to be sitting, so a	Client's humour outside of therapy	3 rd		Metaphor
372	very serious household um and I'm not sure, I'm not sure he has the				
373	outlet or <u>permission</u> to be humorous.				
374	GC: That he does with you				
375	HERMAN: Yeah, yeah and actually I think he finds it very difficult with		1 st	Present	Situation
376	his wife to be humorous because you know their relationship has		3 rd	Past	Situation
377	changed so enormously because of you know her becoming the carer,				Causality
378	him becoming almost well no actually totally incapacitated, um and				
379	that actually takes something away with the fun of life, I think, because	Therapist experiencing humour inside		Present	
380	that translates into the inability to be humorous. And of course it's not	therapy how client experiences humour			
381	just that, but you know he he's also very aware of protecting his wife	outside of therapy		Present	Temporality
382	from her impending loss, it's not just his loss of his life but it's her loss				
383	of him as well and his children's loss, so you know um, in the same way				
384	that with that very first client I was talking about that I was protective	Client's experience of humour outside of		Past	Causality
385	of, not wanting to upset or distress, you know, by being humorous	therapy			
386	disrespectfully, I think he has the same approach with his family. For				
387	him, it somehow, I'm making assumptions here but just based on what	Honouring the whole person		Present	
388	I've seen in the relationship and how it is, I think it somehow makes		1 st		

389	him feel that he he disrespects their grieving process that they're going				
390	through at the moment and will continue to go through. There's			Present	Causality
391	something about honouring I think, which is why we don't use humour				
392	because we think that's honouring actually the truth is the reverse		5 th		
393	because honouring the person is honouring the whole person but its				
394	very hard to see that because it's such a contradiction.				
395	GC: I've never thought about it that way. And I guess when you were	Laughter			
396	talking just now it reminded me of something you said earlier, about	Panic at client being humorous			
397	the very first client that introduced humour and not knowing how to				
398	respond to it and not wanting to feel like you were taking	Importance of recognising and			
399	HERMAN: Actually panicking [laughs]	acknowledging humour to fully hear the			
400	GC: Panicking [laughs] and how you feel that might have added to his	client			
401	distress, did you say?				
402	HERMAN: Yeah, for me that feels the same as someone who comes in			Present	
403	and says 'I'm really distressed' and I say, 'isn't it lovely whether	Previous experiences – resistance			Situation
404	outside', so I've totally ignored and not heard what they're saying, you	Therapist's fear of using humour – not	1 st		
405	know that adds to that client's distress because they're not being heard	client's fear			
406	you know fully, and I think humour works in exactly the same basis, you	Communicating through humour			
407	know I think we need to recognise and acknowledge it. My resistance I	Therapist's reaction to humour		Present	Temporality
408	suppose in those early days were more based around my fear, not	Laughter			Causality
409	really around the client's fear because he was clearly trying attempting			Past	
410	to communicate something in a different way. You know and trying for				
411	it to be allowable ay old me said 'no' [laughs] you know, but in a very				Situation
412	subtle way just by not responding to him thinking 'what the hell do I				
413	say?' but actually you know, it's interesting, I did um, I think that	Client's reaction to therapist's reaction of			
414	happened three times and you know bless him he kept trying	humour	3 rd		
415	GC: Trying to be funny?	Therapist learning from experience			
416	HERMAN: Yeah, well he kept trying to use humour and I think he got				
417	such a non-reaction from me you know so he persevered but it was a	Future experiences - Freedom through	1 st		
418	good learning curve for me as well	humour		Past	

419	GC: IT sounds like it helped with the other clients	Supervision			
420	HERMAN: absolutely, I think it's freed me from the shackles of what we	Genuineness	1 st	Present	Metaphor
421	consider to be appropriate or respectful or honouring or whatever it				
422	may be, you know and um with him, I did because I had that			Past	Situation
423	supervision session 'Oh, I don't know how to handle this, I'm finding it	Therapist addressing humour with client		Present	Character
424	really really really quite tough' you know and very quickly came to				
425	realise with a very good supervisor saying 'why can't you just be you,				
426	and why can't you just let him be him? What are you worried about,			Past	Temporality
427	you know, you know, what's going on?' Um and I actually brought it up				
428	in the next session, and said 'I just realised that this has happened a				
429	few times and I sort of not been able to respond perhaps in a way that				Causality
430	was helpful. How has it been for you? You say.' And he said 'I wanted it				
431	to be slightly more light-hearted', he said 'and I kept trying', you know,				Situation
432	bless him [laughs] 'you know, and then I thought to myself, 'god, you're				Character
433	the bloody therapist here not me'. [Laughs]	Laughter			
434	GC: [Laughs] So it felt it was more like helping you deal with				
435	HERMAN: It was a big learning curve for me I think. In some ways it	Therapist learning from previous	1 st	Past	Causality
436	opened up some actually because I do use humour in a lot of different	experience		Present	
437	ways you know when it comes up with clients um and its made me	Future experiences			
438	more open to it I think in every situation you know because even in				
439	someone's deepest despair, there's still a part of them that has that	Presence of humour in despair			Situation
440	humour. And I think people are very good at looking at themselves and			Present	
441	being able to, you know, put it into slightly different perspective by	New perspective offered by humour			
442	using humour, and saying, 'I feel blood awful but.' You know um so it's				
443	not just in bereavement work or pre-bereavement, but in all my other	Future work			Causality
444	work it's allowed me to be that much more open and accessible to the				
445	humour. And also it's not just about me, in fact it isn't about me it's I				
446	think it allows the client to be able to feel more rounded, more whole,	Making the client feel more whole			
447	more able to be present in the way they that they can be themselves.				
448	GC: so it feels like a more genuine relationship				

449	HERMAN: Yeah, very much so.				
450	GC: Not like the stereotypical, serious therapy sessions				
451	HERMAN: Well that's how we're all taught, isn't it. I think there's				
452	something about you know this profession is that we have and all the		5 th	Present	Situation
453	training can sometimes give us this sense of we have <u>have</u> to present	Training			
454	this certain face and I think as I've gone through in that moment it's not	Therapy profession			Temporality
455	about it's not about putting on the mask and being the therapist, it's			Present	Metaphor
456	about being [HERMAN], it's about being whole and open and congruent	Genuineness and congruity			
457	and all those things and allowing the client to be exactly that as well, or	Allowing the client to be themselves			
458	encouraging the client to be exactly that				
459	GC: Yeah because humour's not actually talked about that much in				
460	training, I don't think it has been at all in mine				
461	HERMAN: We did quite a lot of training sessions in the hospice. <u>It's</u>				
462	<u>interesting coz as a team we're very humorous.</u> I think there's a lot of		5 th	Past	Situation
463	banter that goes around and what have you, but it's sort of safe	Humour at work outside of therapy		Present	
464	because it's away from people who might become distressed by that				Situation
465	sort of humour. But I think that's true of every sort of um every sort of				
466	role that involves death and dying. I mean when you come away from		2 nd	Present	
467	the actual front line, I think there is a lot of black humour that involves,	Black humour			Metaphor
468	there's a sort of way of being able to cope with the feelings that are				
469	attached and normalise. It's interesting because I've never thought to		1 st	Present	
470	ask in the group actually what humour how they use humour, and			Past	
471	that's a similar thing around sex I mean, [REDACTED]				Situation
472	[REDACTED], there's almost a taboo.				
473	Humour and death [winces]	Taboo around humour and death		Present	
474	GC: And what I've found is that lots of people experience humour in				
475	sessions, they just don't talk about it outside of the session, and that's				
476	for a number of reasons				
477	HERMAN: And I think it is a taboo. And certainly that's where when I		1 st		
478	entered into sort of working with terminally ill, it felt very taboo like.				Culture

479	Um. And it doesn't help. It actually feels quite refreshing, it feels very	Experience of humour as being a taboo		Past	Situation
480	one of my clients, there was a lady and we had one session and we had	Experience of humour being refreshing		Present	
481	a bit of a, it wasn't a serious session, it was very, she was a lot of pain,				Character
482	really quite struggling but and she said that she was surrounded by				
483	people sort of um she was lying in bed, she was in bed and she said	Current experience	1 st	Past	
484	'whenever anyone comes, I feel as if I'm lying in a coffin and people are		3 rd		
485	peering over the edge of it', she said 'and all I see are these sad faces'			Present	Metaphor
486	so we had quite a jokey actually you know a silly session, you know, set			Past	Situation
487	by her agenda, that's what she wanted, and at the end of it she said,				
488	'that was so liberating'				
489	GC: Hmm. So she felt freed by it	Client being liberated through humour			
490	HERMAN: Hmm. And I think it is that liberation. It's liberating for me as				
491	well to be able to experience that with her, but I think it's about her	Therapist being liberated through humour	1 st	Present	Causality
492	being able to liberate herself from whether that's distress or you know,		3 rd		
493	just the chains of expectation that are put on you. I suppose there is			Present	Metaphor
494	something about when we when people are terminally ill, that they're				Causality
495	expected to behave in a certain way, in the same way that therapist is				
496	or family member is or what have you				
497	GC: Hmm it's sort of just a new way of being really isn't it				
498	HERMAN: Yeah, there's sort of like um part of us part of those people				
499	gets lost, that's how it feels, they have to sort of bury something, what	Humour helps with regaining something	3 rd plural	Present	
500	they buried, in my sense what gets buried is the vitality	that's lost		Past	Causality
501	GC: The vitality	Vitality		Present	Situation
502	HERMAN: Yeah. Yeah and um I think with allowing things like humour				
503	and all those other taboo areas, that you know we might not address		4 th		
504	very easily, that actually it allows us to live as freely as we can live in	Humour helping to live in the moment		Present	Causality
505	that moment.	Freedom			
506	GC: Mmm				
507	HERMAN: If that makes sense. I've not thought about it in terms of				
508	vitality really, which is a strange word to use in terms of death			Past	

509	GC: I don't know if it's maybe a sense of clinging on to the vitality			Present	Break
510	before that's gone too or something else, but maybe just reminding				
511	you that despite the tragedy of their terminal illness, there's still some				
512	vitality there, that it's not all gone				
513	HERMAN: Absolutely. It sort of brings to mind, I was thinking, I don't		1 st	Present	Break
514	know where the hell this has come from so if I were to write a book				
515	around this, it would be one of those jokes that people put on their				
516	gravestones, sort of 'I'm not dead yet' you know, which means I'm				
517	allowed to laugh, I'm allowed to do all the things I always ever did, why	Permission to laugh			Situation
518	does it, you know just because I have this, why does it mean I have to	Not dead yet		Present	
519	die before my time? Which is effectively, often what happens. We feel		4 th		Causality
520	that everything gets closed back in again.				
521	GC: And so humour then allows the person to stay open and playful				
523	HERMAN: And not die. And not die. And not die prematurely if that				
524	makes sense. Not die in their personality and their way of being. So it	Vitality of humour – staying alive with it		Present	Metaphor
525	allows them to be more than a shell of expectation that people place				Causality
526	on them, or even that they place on themselves				Situation
527	GC: Hm, hm. Thank you. That's brilliant. I think that's covered				
528	everything and more than I was expecting. Was there anything else you				
529	wanted to add or any questions you wanted to ask?				
530	HERMAN: Me giving myself permission somehow, but also for the client				
531	to have permission. Very challenging I think for the therapist when	Permission through humour	1 st	Present	Grammar
532	you're not used to that sort of work.		2 nd		Situation
535	GC: Hmm. It's difficult just from the offset working with terminally ill				
536	clients and everything that comes up for you then, and then for				
537	humour to also be an issue is just more really isn't it				
538	HERMAN: I think it's all this preconception that we have about you		4 th		
539	know, again, it's the whole taboo thing, when people are dying you		2 nd	Present	Culture
540	can't be humorous. And yet, when I go back to my own experiences,	Taboo	1 st		
541	you know I lost my partner in ■■■, I lost my father, you know I was one			Present	Causality

542	of his primary carers, and humour was an everyday part of what we did	Therapist's personal experiences of		Past	Situation
543	in both ways. We were always very humorous and actually it helped	humour and death			Plot
545	cope, it was that normalising.	Coping mechanism; normalising			
546	GC: Maybe It would have been unbearable if humour wasn't there for				
547	both of you				
548	HERMAN: Yeah, but for whatever reason, that hadn't translated into	Previous experience: Personal didn't feel		Past	Causality
549	that therapeutic stance. Again, it's that sort of preconceived idea of	therapeutic		Present	Culture
550	therapists being this upright, whatever that person is	Preconceived idea of therapy			Character
551	GC: Stoic				
552	HERMAN: Absolutely and you know, sort of wanting to take care of the	Previous experience	1 st	Present	
553	client, and I think there's a contradiction again for sometimes you know				Culture
554	I think certainly in British culture, there's something about humour	Culture			Situation
555	being quite disparaging. Often annihilating for some people. Very	Disparaging humour			Metaphor?
556	unhelpful for some people, very discouraging. And yet it doesn't have				
557	to be that way, but we have this, that's my sense of, humour's almost a			Present	
558	bit of a put down				
559	GC: It can be used as a sort of weapon almost				
560	HERMAN: And that's possibly why it feels uncomfortable in a	Uncomfortable humour	2 nd	Present	
561	therapeutic session, because if you come in with that sort of remit of				Situation
562	what humour is, you know, how can you do something that's possibly	Insulting humour			
563	insulting? You know, in a therapy session you're there to help and	Role of therapy	1 st	Present	
564	support and all this sort of stuff that again, there's that contradiction	Contradiction		Future?	Causality
565	there. I, I think that it would actually be impossible to do any sort of	Humour as essential			
566	terminal work without humour. Actually, impossible to do anything				
567	therapeutic work without humour.				
568	GC: Maybe more so with terminal patients or just the same amount?				
569	HERMAN: I think the humour is more raw with terminal patients and I		1 st		
570	think it's more honest	Difference between humour with TI and			Situation
571		other clients		Present	
572	GC: And you said that it appears much, much earlier in these sessions				
573	than with other clients maybe				

574	HERMAN: Very much. I think I only have four terminal clients but I think	Humour being present in early sessions	1 st	Present	Temporality
575	all of them have brought it in certainly within the first few sessions. You				
576	know, and sort of brought that humorous side in. Um, and if I think				
577	about my, you know the other side of that, that that relationship, the				
578	bereavement clients, often they won't bring that in until you're				
579	certainly into your certainly second or third month.	Difference between humour with TI and			
580	GC: Or if at all, actually I've found. There are still some sessions where	other clients			
581	I'm like, 'there's no humour here'				
582	HERMAN: Yeah you're right, it can take. I'm trying to think. I don't know		1 st	Present	Character
583	what it is but I think I've been quite lucky with some of my clients, they			Past	Temporality
584	are sort of um quite gregarious people, I finished with a client last week				
585	after 2 years doing bereavement work. Very serious lady and				
586	everything else, and it took her about four months but I think she was				
587	so wrapped up in her own sorrow and grief that actually humour, it's	Humour in bereavement	3 rd		Causality
588	interesting looking at it again, it's for her humour was about living and				Metaphor
589	she felt that she'd died as part of that grieving process, she'd lost her			Past	Plot
590	husband and therefore there was no life to live. Her purpose had gone				
591	so humour sort of went out the window for her. And I suppose, and I'm				
592	just reflecting back that the changes she went through when she				
593	allowed humour back in, it revitalised her again	Revitalised through humour			Causality
594	GC: So it's not just the patient				
595	HERMAN: No I think it's actually something that is it's very it's very key				
596	to engaging in life	Engaging with life through humour		Present	Causality?
597	GC: And I think that goes back to what you were saying about being the				
598	whole you that you can be				
599	HERMAN: Yeah, very much. Yeah, I'm not going to put a song and				
600	dance routine on that			Future	Metaphor
601	GC: Oh, please? [Laughs]				Break
602	HERMAN: [Laughs] Actually, the trouble is I might be tempted to, just	Laughter			
603	as you know.				

604	GC: So do you think you find yourself waiting for the patient to bring				
605	the humour before you do or might there be some times when you are				
606	humorous and see how they respond?				
607	HERMAN: It depends on how well I've connected with the client. I mean				
608	if the client is very guarded, I mean I had one client who was, that	Relationship context	1 st	Present	Causality
609	found it very difficult just to, just to touch base with his feelings, it was			Past	Character
610	just anger, anger anger anger . It took a while before humour was	Building relationship			Temporality
611	allowed. You know and even, I say it took a while, it was only about	Allowing humour			
612	three sessions with him, but it was very um, it was very measured. It				
613	didn't feel as spontaneous but you know, I'm sure it was spontaneous	Therapist's experience of client's			
614	but it didn't feel that somehow, um and I think it would have been	experience of humour			
615	wrong for me to introduce it because of where he was. I think it would	Difficulty with therapist initiating humour			Situation
616	have been very difficult to allow me to be humorous because he was so				Causality
617	caught up in that situation that he was in. And actually I think it's right				
618	for the client, the patient to take the lead in that, you know I think it's	Client initiating humour		Present	
619	more about me responding in an open way, allowing the possibility,				
620	without pushing it, if that makes sense. So I think I'd always respond to				
621	where the client was coming from. I mean, I, I, in other situations, non-				Situation
622	terminal care, I remember I'd been working with a client for some,			Future?	
623	some time, probably about 2 or 3 months and I, I made a very probably	Humour with non TI clients			Character
624	very stupid attempt of humour for the first time and it didn't go down				
625	terribly well, you know it can actually cause a bit of a rupture, which we			Past	Plot
626	got over and it was helpful, but it just shows how we can misread, you	Humour causing a rupture			Metaphor
627	know, um				Causality
628	GC: We might think it's ok but it's not				
629	HERMAN: There's something about how um, whilst I was trying to				
630	alleviate something, um and just sort of make a an aside comment as it	Humour with a non TI client			
631	were, as a sort of way of reflecting back how we could look at this in	Alleviating something through humour		Past	Situation
632	different ways, you know there's not just one way of, you know,	Humour offering a different perspective	1 st		
633	coming away from black and white thinking, for the client but she took		3 rd	Present	

634	it very much as a major insult that what she was feeling wasn't right,	Insulting humour		Past	Metaphor
635	you know and that's where that belittling sense comes in I think. You			Present	Causality
636	know, disallowing her feelings for what they are. She did lighten up				Temporality
637	after a while, but.				
638	GC: She gave you permission hen				
639	HERMAN: It took two or three sessions to to actually get over the	Allowing humour Therapist initiating humour	3 rd	Past	Temporality
640	rupture of the feelings around what I'd said and how that had made her				
641	feel, but it also allowed her to reflect on where she was at and what				
642	she wasn't doing or allowing herself to do, ie that humour, so that's an				
643	argument for saying maybe it's right for the therapist to introduce it,				
644	but, I don't know, it's a hard judgement call			Present	Causality
645	GC: I think maybe it's something that can't be generalised, it seems to				
646	be, at least in your experience, very individual				
647	HERMAN: I think, I go with my gut feeling. Certainly when it comes to	Therapist's instinct	1 st	Present	Causality
648	the clients we're talking about, I will always allow them to bring it in	Client initiating humour			Situation
649	rather than me bringing it in, because that actually feels more	Respecting client			
650	respectful and more being there for them. You know, what's that term,	Therapist in service of the client			
651	'being there in the service of the client' you know, not in my service but				
652	in their service, so it's reacting rather than proacting. Proacting?				Break
653	[laughs]				
654	GC: [laughs] I know what you mean.	Laughter			
655	HERMAN: No, important part of therapy I think. Essential part of	Essentialness of humour	1 st		
656	therapy I think. I don't think I could do this job if we didn't have		4 th		
657	humour.			Present	Situation
658	GC: You were mentioning you and your team being humorous outside				
659	of here as well, there's something quite magical about the humour that				
660	is around in the room when				
661	HERMAN: I don't think we actually give it enough credence. I think it's				
662	good to sort of you know, be more open. It all comes down to these		1 st		
663	taboo subjects doesn't it and how, how can we normalise this stuff,	Being open through humour			Causality

664	GC: And not make it such a shocking thing.				
665	HERMAN: I had situations with, I do a lot of work with HIV charities, and				
666	I have people coming through having just been diagnosed with being				
667	HIV positive and of course the whole world's just ended for them		1 st	Present	Situation
668	because they've got this quite major diagnosis, you know um and				
669	actually I'm sort of, I've found that using humour in those situations can				
670	normalise, so rather than being caught up in the all the dread and				
671	awfulness of this diagnosis actually there's a life outside of that as well,	Humour normalises		Past	Causality
672	and that life includes lots of different facets, humour being part of it, so	Life outside of dread		Present	
673	I think humour works in lots of different areas.				
674	GC: Thank you. That's been really good.				
675	HERMAN: That's the first interview out of the way then. Did you find				
676	much research on it?				Break
678	GC: There's not much on terminal illness and humour at all, there's				
679	some on humour but most of it is psychoanalytic, similarly not much on				
680	terminal illness but that's growing, but very little on both, so I thought,				
681	cool, I'll get my hook onto that niche. But most of what was there was				
682	psychoanalytic, interpretation				
683	HERMAN: And it's always about a defence going on, or <u>an avoidance</u> ,				
684	and they've taken the vitality out of it.				
685	[In thinking about jokes]... <u>I'm</u> great for the one-liners, the whole				
686	precept of jokes, going into therapy and telling your client a joke, that			Present	
687	doesn't work so well – it's too contrived, too formulaic, too organised	Jokes vs humour			Causality
688	rather than allowing something to be. I'm pretty sure some of my		1 st		
689	clients have told me jokes. I don't know what they are, but I'm sure				
690	that people have said something to me.				
691	HERMAN: I think it's a lovely subject....				
692	[Talked about his own therapy with a gestalt therapist where he was				Break
693	allowed to choose toys, one that represented himself, one that				
694	represented his therapist and one that represented the process for				

695	him]: I wonder, it just strikes <u>me</u> . I wonder how that might work in	Future experience			
696	working with a terminally ill client. There's something about the	Using toys in therapy – or not		Present	
700	appropriateness or inappropriateness of using that perhaps				
701	GC: That reminds me of how you felt with that first client				
702	HERMAN: It feels comfortable doing that in a normal session. A normal				
703	session, they're all normal sessions, but you know it's about <u>respect</u> , it's	TI sessions not being 'normal' sessions		Present	Situation
704	about respecting the end of life. And do toys do that? But why wouldn't			Future?	
705	they? It's an interesting question for me to hold.				

References

- Aabom, B., Kragstrup, J., Vondeling, H., Bakketeig, L.S., & Stovring, H. (2005). Defining cancer patients as being in the terminal phase: Who receives a formal diagnosis, and what are the effects? *Journal of Clinical Oncology*, 23 (30):7378-7379.
- Aeschylus (1961). *Prometheus Bound and Other Plays* (Trans. P. Vellacott). London: Penguin Classics.
- Allen, W. (1993). *The Illustrated Woody Allen Reader*. New York: Knopf.
- Allport, G. W. (1955). *Becoming: Basic Considerations for a Psychology of Personality*. New Haven: Yale University Press.
- Altheide, D. L., & Johnson, J. M. (2013). Reflections on interpretive adequacy in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (4th ed.). Thousand Oaks, CA: Sage Publications, pp. 381-411.
- Alvarez, A. (1992). *Live Company: Psychoanalytic Psychotherapy with Autistic, Borderline, Deprived and Abused Children*. London: Routledge.
- Andrews, M., Squire, C., & Tamboukou, M. (2008). *Doing Narrative Research*. London: Sage.
- Angus, L. E. & McLeod, J. (2004). *The Handbook of Narrative and Psychotherapy: Theory, Practice and Research*. London: Sage.
- Aristotle (335BC) *Poetics*. In: W. Harmon (Ed.), *Classic Writings on Poetry* (2003). New York: Columbia University Press.
- Ashworth, P.D. (2007). The variety of qualitative research. Part two: non-positivist approaches. *Nurse Education Today*, 17 (3): 219-224.
- Bader, M. J. (1993). The Analyst's Use of Humor. *Psychoanalytic Quarterly*, 62:23-51.
- Baker, R. (1993). Some reflections on humour in psychoanalysis. *The International Journal of Psychoanalysis*, 74 (5): 951-960.
- Barron, J. W. (2013). *Humor and Psyche: Psychoanalytic Perspectives*. London: Routledge.
- Barry, A-M & Yuill, C. (2012). *Understanding the Sociology of Health: An Introduction*. London: Sage Publications.
- Barwick, N. (2012). Looking on the bright side of life: Some thoughts on developmental and defensive uses of humour. *Psychodynamic Practice*, 18(2): 163-179.
- Beattie, J. (1779). Essay on Laughter and Ludicrous Composition. In M. Billig (2005), *Laughter and Ridicule: Towards a Social Critique of Humour*. London: Sage Publications.
- Becker, E. (1973). *The Denial of Death*. New York: Free Press Paperbacks.
- Bennet, H. J. (2003). Humor in Medicine. *Southern Medical Journal*. 96(12):1257-1261.
- Bergler, E. (1956). *Laughter and the sense of humor*. Michigan: Intercontinental Medical Book Corp.
- Bergmann, M. S. (1999) The Psychoanalysis of Humor and Humor in Psychoanalysis, in J. W. Barron (2013), *Humor and Psyche: Psychoanalytic Perspectives*. London: Routledge (pp. 11-30).

- Bergson, H. (2008[1900]) *Laughter: An essay on the meaning of the comic* (trans. C. S. H. Brereton). London: Macmillan and Co.
- Berlyne, D. E. (1960). *Conflict, arousal and curiosity*. New York: McGraw-Hill Book Company.
- Bevis, M. (2012). *Comedy: A very short introduction*. Oxford: Oxford University Press.
- Busey, G. (2014). *Celebrity Big Brother UK*. Channel 5.
- Block, S. & McNab, D. (1987). Attitudes of British psychotherapists towards the role of humour in psychotherapy. *British Journal of Psychotherapy*, 3: 216-25.
- Bloomfield, I. (1980) Humour in psychotherapy and analysis. *International Journal of Social Psychiatry*. 26 (2): 135-141.
- Bradbury-Jones C., Irvine, F., Sambrook, S. (2007). Unity and detachment: a discourse analysis of doctoral supervision. *International Journal of Qualitative Methods*, 6 (4), 81-96.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2):77-101.
- Brinkmann, S., & Kvale, S. (2008). Ethics in qualitative psychological research. In C. Willig, & W. Stainton-Rogers (Eds.), *The SAGE handbook of qualitative research in psychology*. (pp. 263-279). London: Sage Publications.
- Britton, R. (2003). *Sex, Death, and the Superego: Experiences in Psychoanalysis*. London: Karnac.
- Brockmeier, J. & Harré, R. (2001). Narrative: Problems and Promises of an Alternative Paradigm In: Brockmeier, J. & Carbaugh, D. (Eds) *Narrative and Identity: Studies in Autobiography, Self and Culture*. Philadelphia, PA: John Benjamin Publishing Company (pp.39-58).
- Bruner, J. (1986). *Actual Minds, Possible Worlds*. Cambridge, MA: Harvard University Press.
- Bruner, J. (1987). Life as narrative. *Social Research*, 54 (3):11-32.
- Bruner, J. (1990). *Acts of Meaning*. Cambridge, MA: Harvard University Press.
- Bruner, J. (1991). The Narrative Construction of Reality. *Critical Inquiry*, 18: 1-21.
- Bruner, J. (2004). Life as Narrative. *Social Research*, 71(3):691-710.
- Bucholtz, M. (2000). The politics of transcription, *Journal of Pragmatics*, 32:1439-1465.
- Buckman, E. S. (1994). *The Handbook of Humor: Clinical Applications in Psychotherapy*. Florida: Krieger Publications.
- Camic, P. M., Rhodes, J. E. & Yardley, L. (2003). Naming the Stars: Integrating Qualitative Methods into Psychological Research, in P.M. Camic, J.E. Rhodes & L. Yardley (Eds.) *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*. Washington DC: American Psychological Association (pp. 3-16).
- Cancer Research UK (2012). *Enemy TV Ad 2012* [advertisement] Retrieved from: http://www.youtube.com/watch?v=jWuyPi_nuJE [Accessed 25th May 2013].
- Carr, W. (2006). Philosophy, Methodology and Action Research. *Journal of Philosophy of Education*, 40 (4): 421-435.
- Carson, D., Gilmore, A., Perry, C., & Gronhaug, K. (2001). *Qualitative Marketing Research*. London: Sage.
- Cartwright, M. (2013). Greek Tragedy. *Ancient History Encyclopaedia*. Retrieved from: http://www.ancient.eu/Greek_Tragedy/

- Charmaz, K. (2003) Grounded Theory, in J. A. Smith (Ed.), *Qualitative Psychology: A practical Guide to Research Methods*. Thousand Oaks CA: Sage Publications (pp. 81-110).
- Chase, S. E. (1995). Taking Narrative Seriously: Consequences for Method and Theory in Interview Studies, in R. Josselson (Ed.) *Interpreting Experiences: The Narrative Study of Lives*. Thousand Oaks CA: Sage Publications (pp. 1-26).
- Chasseguet-Smirgel, J. (1988). The triumph of humor, in J. W. Barron (2013): *Humor and Psyche: Psychoanalytic Perspectives*. London: Routledge.
- Christie, G. L. (1994). Some psychoanalytic aspects of humour. *International Journal of Psycho-Analysis*, 75:479-484.
- Czarniawska, B. (2004). *Narratives in Social Science Research: Introducing Qualitative Methods*. London: Sage Publications.
- De Castro, A. D., (2003) Introduction to Giorgi's existential phenomenological research method. *Psicologia Desde el Caribe Universidad del Norte*, 11: 45- 56.
- Denzin, N. K., & Y. S. Lincoln, (Eds.) (2000) *Handbook of Qualitative Research*, 2nd edition. Thousand Oaks, CA: Sage.
- Department of Health (2008). End of Life Care Strategy. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf
- Dixon, N. R. (1980). Humor: A cognitive alternative to stress. *Stress and Anxiety*, 7:281-289.
- Dor, J. (1998). *Introduction to the Reading of Lacan: The Unconscious Structured Like a Language*. New Hampshire: Other Press.
- Du Pré, A. (1998). *Humor and the Healing Arts: A Multimethod Analysis of Humor in Healthcare*. New Jersey: Lawrence Erlbaum.
- Durkin, K. F. (2003). Death, Dying, and the Dead in Popular Culture. In C. D. Bryant and D. L. Peck (Eds.), *Handbook of Death and Dying*. London: Sage.
- Dribble, H. (2004). *Philosophical Investigations from the Sanctity of the Press*. Lincoln, NE: iUniverse, Inc.
- Eckardt, A. R. (1996). *On the Way to Death: Essays toward a comic vision*. New Jersey: Transaction
- Eisner, E. W. (1998). The enlightened eye: Qualitative inquiry and the enhancement of educational practice. New Jersey: Prentice-Hall.
- Elliott, J. (2005). *Using Narrative in Social Research. Qualitative and Quantitative Approaches*. London: Sage.
- Epictetus (125). Enchiridion. In J. Morreall (2009) *Comic Relief: A Comprehensive Philosophy of Humor*. West Sussex: Blackwell Publishing.
- Erdman, L. (1994). Laughter Therapy for Patients with Cancer. *Journal of Psychosocial Oncology*. 11(4): 55-67.
- Fabian, E. (2002). On The Differentiated Use Of Humor And Joke In Psychotherapy *The Psychoanalytic Review*, 89 (3):399-412.
- Fairclough, N. L. (2003). *Analysing Discourse: Textual Analysis for Social Research*. London: Routledge.
- Feifel, H. (Ed.). (1977). *New Meanings of Death*. New York: McGraw-Hill.
- Ferenczi, S. (1911). The psychoanalysis of wit and the comical. In: J. W. Barron (2013), *Humor and Psyche: Psychoanalytic Perspectives*. London: Routledge.
- Finlay, L., (2003). The reflexive journey: mapping multiple routes, in Finlay, L., & B. Gough, (Eds.), *Reflexivity: a practical guide for researchers in health and social science*. Oxford: Blackwell Publishing.

- Finlay, L. (2009). *Debating phenomenological research methods*, *Phenomenology & Practice*, 3, 6-25.
- Flick, U. (1997). The Episodic Interview: Small scale narratives as an approach to relevant experiences. Retrieved from: <http://www.lse.ac.uk/methodology/pdf/qualpapers/flick-episodic.pdf>.
- Flick, U. (2002). *An Introduction to Qualitative Research: Theory, Method and Application* (2nd ed.). Sage Publications: London.
- Flick, U. (2006). *An Introduction to Qualitative Research* (3rd ed.). London: Sage.
- Foucault, M. (1990[1976]). *The History of Sexuality: Volume 1*. (Trans. R. Hurley). Random House: New York.
- Foucault, M. (1961). *Madness and Civilization: A History of Insanity in the Age of Reason*. New York: Random House.
- Foucault, M. (1984). The order of discourse. In Shapiro, M. J. (ed.) *Language and Politics*. Oxford: Blackwell (pp. 108-138).
- Fowler, H. W. (1926). *A Dictionary of Modern English Usage*. Oxford: Oxford University Press.
- Fox, S. (1990). The Ethnography of Humour and the Problem of Social Reality. *Sociology*, 24 (3): 431-446.
- Franzini, L. R. (2001). Humor in therapy: The case for training therapists in its uses and risks. *The Journal of General Psychology*, 128 (2): 170-193.
- Freud, S. (1990[1927]). Humour, in *Art and Literature*, Penguin Freud Library, Vol. 14. Harmondsworth: Penguin.
- Freud, S. (1992[1905]). *Jokes and their relation to the unconscious* (Standard Edition). London: Penguin Books.
- Friedman, H. H. (2000). Humour. *International Journal of Humor Research*, 23 (3): 258-285.
- Frings, W. (1996). Humor in der Psychoanalyse: Eine Einführung in die Möglichkeiten humorvoller Intervention. In: E. Fabian (2002), On The Differentiated Use Of Humor And Joke In Psychotherapy, *The Psychoanalytic Review* 89 (3):399-412.
- Fry, W. & Salameh, W. (Eds.). (1987). *Handbook of humor and psychotherapy: Advances in the clinical use of humor*. Sarasota, FL: Professional Resources. Exchange, Inc.
- Gadamer, H-G. (1975). *Truth and Method* London: Continuum.
- Gergen, K. J. (1999). *Invitation to Social Construction*. Sage Publications: Thousand Oaks, CA.
- Gimenez, J. C. (2010). Narrative Analysis in Linguistic Research. In L. Litosseliti, *Research Methods in Linguistics*. London: Continuum (pp.198-215).
- Giorgi, A. (1975). An Application of Phenomenological Method in Psychology. In A. Giorgi, C. T. Fischer, and E. L. Murray (Eds.), *Duquesne Studies in Phenomenological Psychology: Volume II*. Pittsburgh: Duquesne University Press (pp. 82-103).
- Giorgi, A., (1985). Sketch of a psychological phenomenological method. In: Giorgi, A. (Ed.) *Phenomenology and Psychological Research*, Pittsburgh, PA: Duquesne University Press.
- Giorgi, A., (1994). A phenomenological perspective on certain qualitative research methods. *Journal of Phenomenological Psychology*, 25 (2):190-220.
- Giorgi, A. (2008). Concerning a serious misunderstanding of the essence of the phenomenological method in psychology. *Journal of Phenomenological Psychology*, 39, 33-58.

- Golan, G., Rosenhein, E. & Jaffe, Y. (1988). Humour in Psychotherapy. *British Journal of Psychotherapy*, 4 (4):393-400.
- Goldin, E., & Bordin, T. (1999). The use of humor in counselling: The laughing cure. *Journal of Counseling and Development*, 77: 405-410.
- Golomb, J. (1995). *In Search of Authenticity: Existentialism from Kierkegaard to Camus*. New York: Routledge.
- Golub, R. R. (1979). *An investigation of the effect of humor in counseling*. Unpublished doctoral dissertation, Purdue University.
- Grotjahn, M. (1957). *Beyond Laughter: Humour and the subconscious*. New York: McGraw Hill
- Grotjahn, M. (1971). Laughter in Group Psychotherapy. *International Journal of Group Psychotherapy*, 21 (2): 234-238.
- Gruner, C. R. (1997). *The game of humor: A comprehensive theory of why we laugh*. New Jersey: Transaction Publishers.
- Guba, E. G., & Y. S. Lincoln, (1994). Competing paradigms in qualitative research. In Denzin, N. K. & Lincoln, Y. S. (eds.) *Handbook of Qualitative Research*. London: Sage Publications (pp. 105-117).
- Guignon, C. (1998). Narrative explanation in psychotherapy. *American Behavioral Scientist*, 41(4): 558- 577.
- Guignon, C. (2002). Hermeneutics, authenticity and the aims of psychology. *Journal of Theoretical and Philosophical Psychology*, 22: 83-102.
- Guignon, C. (2004). *On Being Authentic*. London: Routledge.
- Haigh, R. A. (1986). Therapeutic uses of humor. *American Journal of Psychotherapy*. 40(4): 543-553.
- Halling, S. (2008). *Intimacy, transcendence, and psychology: Closeness and openness in everyday life*. New York: Palgrave Macmillan.
- Halling, S., Leifer, M., & Rowe, J. O. (2006). Emergence of the dialogal approach: Forgiving another. In C. T. Fischer (Ed.), *Qualitative Research Methods for Psychology: Introduction through Empirical Studies* (pp. 247-278). New York: Academic Press.
- Hart, C. (1998). *Doing a Literature Review: Releasing the Social Science Research Imagination*. London: Sage.
- Heidegger, M. (1962[1927]). *Being and Time* (Trans. J. Macquarrie & E. Robinson). Oxford: Blackwell Publishing.
- Heidegger, M. (1971). *On the Way to Language* (Trans. P. D. Hertz). San Fransisco: Harper Collins.
- Hobbes, T. (1651) *Leviathan*. Accessed from: <http://socserv.mcmaster.ca/econ/ugcm/3ll3/hobbes/Leviathan.pdf>
- Husserl, E. (1960[1931]). *Cartesian Meditations. An Introduction to Phenomenology* (Trans. Cairns, D.). The Hague: Martinus Nijhoff.
- Hutcheson, F. (1725). Thoughts on Laughter. In: E. Telfer, E. (1995). Hutcheson's Reflections Upon Laughter. *The Journal of Aesthetics and Art Criticism*. 53:4, pp:359-369.
- Illich, I. (1976). *Medical Nemesis: The Expropriation of Health*. Pantheon Books: New York.
- Jackson, E. (1977). Counseling the dying. *Death Education*, 1 (1): 27-39.
- Jacobson, H. (1997). Seriously funny: From the ridiculous to the sublime. In: A. Lemma (2000). *Humour on the couch: Exploring Humour in Psychotherapy and in Everyday Life*. London: Wiley Blackwell.

- Janik, V. K. (1998). *Fools and Jesters in Literature, Art and History: A Biographical Sourcebook*. Connecticut: Greenwood Press.
- Josselson, R. & Lieblich, A. (2001). Narrative Research and Humanism. In: K. J. Schneider, J. F. T. Bugental & J. F. Person (Eds.), *The Handbook of Humanistic Psychology: Leading Edges in Theory, Research and Practice*. Thousand Oaks CA: Sage Publications (pp.275-288).
- Kant, I. (2006[1892]). *Critique of Judgement* (Trans. J. C. Meredith). New York: Hafner Press.
- Kerr, W. (1967). *Tragedy and Comedy*. Simon and Schuster: New York.
- Kierkegaard, S. (1992[1841]). *Concluding unscientific postscript to the philosophical Fragments* (Trans. H. V. Hong & E. H. Hong). Princeton, NJ: Princeton University Press.
- Killeen, M. E. (1991). Clinical Clowing: Humor in Hospice Care. *The American Journal of Hospice and Palliative Care*, 8(3): 23-27.
- Killinger, B. (1977). The place of humor in adult psychotherapy. In: A. Chapman and H. Foot (Eds.), *It's a Funny Thing, Humour!* Oxford: Pergamon Press.
- Kisner, B. (1994). The use of humor in the treatment of people with cancer. In: E. S. Buckman (Ed.), *Handbook of Humor: Clinical Applications in Psychotherapy*. Florida: Krieger Publications.
- Klein, A. (1989). *The Healing Power of Humor: Techniques for Getting through Loss, Setbacks, Upsets, Disappointments, Difficulties, Trials, Tribulations and All That Not-So-Funny Stuff*. New York: Penguin Putnam.
- Klein, A. (1998). *The Courage to Laugh: Humor, Hope and Healing in the Face of Death and Dying*. New York: Penguin Putnam.
- Klein, A. (2014). *The Perspective of Humor*. Retrieved from: <http://www.allenklein.com/articles/perspect.htm>.
- Klein, M. (1961). *Narrative of a Child Analysis*. London: Hogarth Press.
- Koestler, A. (1964). *The Act of Creation*. London: Penguin Books.
- Kris, E. (1938). Ego development and the comic. *International Journal of Psychoanalysis*, 19: 77-90.
- Kubie, L. (1971). The destructive potential of humor in psychotherapy. *American Journal of Psychiatry*, 127: 861-866.
- Kübler-Ross, E. (1970). *On Death and Dying: What the dying have to teach doctors, nurses, clergy and their own families*. New York: Scribner.
- Kuhlman, T. L. (1994). *Humor and Psychotherapy*. New Jersey: Jason Aronson
- Kuiper, N. A. & Martin, R. A. (1998). Laughter and stress in daily life: Relation to positive and negative affect. *Motivation and Emotion*, 22:133-153.
- Kvale, S., (1996) *Interviews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage.
- Labov, W. (1972). *Sociolinguistic patterns*. Philadelphia: Pennsylvania State University Press.
- Langdrige, D. (2008). Phenomenology and critical social psychology: directions and debates in theory and research. *Social and Personality Psychology Compass*, 2 (3): 1126-1142.
- Lederberg, M. S. & Holland, J. C. (2011). *Supportive Psychotherapy in Cancer Care: An Essential Ingredient of All Therapy*. In: M. Watson & D. W. Kissane (Eds.) *Handbook of Psychotherapy in Cancer Care*. Chichester: John-Wiley (pp. 1-14).
- Leech, C. (1968). *Twelfth Night and Shakespearean Comedy*. Toronto: University of Toronto Press.

- Lemma, A. (2000). *Humour on the couch: Exploring Humour in Psychotherapy and in Everyday Life*. London: Wiley Blackwell.
- LeShan, L. (1990). *Cancer as a Turning Point: A handbook for people with cancer, their families and health professionals*. New York: Penguin.
- Levinthal, C. F. (1988). *Messengers of Paradise: Opiates and brain chemistry*. New York: Anchor Press/Doubleday.
- Lieblich, A., Tuval-Mashiach, R. & Zilber, T. (1998). *Narrative Research: Reading, Analysis and Interpretation*. Thousand Oaks, CA: Sage.
- Lindenman, C. (1995). *The Meanings and Functions of Humor: The Use of Humor in Psychotherapy*. New Jersey: Jason Aronson.
- Loewenthal, D. (2011). *Postexistentialism and the Psychological Therapies*. London: Karnac Books.
- Loewenthal, D. (2016). *Existential Psychotherapy and Counselling After Postmodernism: The Selected Works of Del Loewenthal*. London: Routledge.
- Loewenthal, D. & R. Snell, (2003). *Postmodernism for Psychotherapists: A Critical Reader*. London: Routledge.
- Loh, J. (2013). Inquiry into issues of trustworthiness and quality in narrative studies: A perspective. *The Qualitative Report*, 18(65): 1-15.
- Lothane, Z. (2008a). The uses of humor in life, neurosis and in psychotherapy: Part 1. *International Forum of Psychoanalysis*, 17(3): 180-188.
- Lothane, Z. (2008b). The uses of humor in life, neurosis and in psychotherapy: Part 2. *International Forum of Psychoanalysis*, 17(4): 232-239.
- MacHovec, F. (1991). Humour in therapy. *Psychotherapy in Private Practice*, 9, 25-33.
- Madill, A. & Doherty, K. (1994) 'So You Did What You Wanted Then': Discourse Analysis, personal agency, and psychotherapy. *Journal of Community and Applied Social Psychology*, 4: 261-273.
- Mager, M., & Cabe, P. A. (1990). Effect of death anxiety on perception of death-related humor. *Psychological Reports*, 66:1311-1314.
- Mann, D. (1991). Humor in Psychotherapy. *Psychoanalytic Psychotherapy* 5(2):161-170.
- Maslow, A. (1954). *Motivation and Personality*. New York: Harper.
- May, R. (1953). *Man's Search for Himself*. New York: W. W. Norton.
- May, R. (1973). *Paulus: Tillich as spiritual teacher*. Dallas: Saybrook Publishing Company.
- McAdams, D. P. (1993). *The Stories we live by: Personal myths and the making of the self*. New York: Morrow.
- McGhee, P. & Goldstein, J. (1983). *Handbook of Humor Research*. New York: Springer-Verlag.
- McGuire, P. A. (1999). More psychologists are finding that discrete uses of humor promote healing in their patients. *APA Monitor*, 30(3): 1.
- McLeod, J. (2001). An administratively created reality: some problems with the use of self-report questionnaire measures of adjustment in counselling/psychotherapy outcome research. *Counselling and Psychotherapy Research*, 1(3): 215-226.
- McNamara, B. (2006). A method for defining and estimating the palliative care population. *Journal of Pain and Symptom Management*. 32 (1): 5-12.
- McQuillan, M. (2000). *The Narrative Reader*. New York: Routledge.
- Merleau-Ponty (1968). *The Visible and the Invisible* (trans. A Lingis). Evanston: Northwestern University Press.

- Mishler, E. G. (1986). *Research Interviewing: Context and Narrative*. Harvard University Press: Cambridge, MA.
- Morreall, J. (1983). Humor and Emotion. *American Philosophical Quarterly*, 20(3): 297-304.
- Morreall, J. (2009). *Comic Relief: A Comprehensive Philosophy of Humor*. Chichester: Wiley-Blackwell.
- Mosak, H. (1987). *Ha ha and Aha: The Role of Humor in Psychotherapy*. New York: Routledge.
- Moustakas, C. (1990). *Heuristic Research Design, Methodology and Applications*. London: Sage.
- Moustakas, C. (1994). *Phenomenological Research*. London: Sage.
- Murray, T. R. (2003a). Blending qualitative and quantitative research methods in theses and dissertations. *Journal of Mixed Methods Research*, 1: 295-297.
- Murray, M. (2003b). Narrative Psychology and Narrative Analysis. In: P. Camic, J. E. Rhodes & L. Yardley, (Eds.), *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*. Washington DC: American Psychological Association (pp.95-112).
- National Institute for Clinical Guidance (2004). *Guidance on Cancer Services Improving Supportive and Palliative Care for Adults with Cancer The Manual*. Retrieved from: <https://www.nice.org.uk/guidance/csgsp/evidence/supportive-and-palliative-care-the-manual-2>.
- Newirth, J. (2006a). Jokes and their relation to the unconscious: Humor as a fundamental emotional experience. *Psychoanalytic Dialogues*, 16:557 - 571.
- Newirth, J. (2006b). The analyst as comic and the comic in analysis. *Psychoanalytic Dialogues*, 16: 579 - 584.
- Nietzsche, F. (1978[1883]). *Thus Spoke Zarathustra* (Trans. W. Kaufmann). New York: Penguin.
- O'Donovan, D. (1985). Laughter, hilarity and cognitive change. *Psychotherapy in Private Practice*, 3(4): 61-66.
- O'Gorman, S. G. (1998). Death and Dying in contemporary society: an evaluation of current attitudes and the rituals associated with death and dying and their relevance to recent understandings of health and healing. *Journal of Advanced Nursing*, 27, 1127-1135.
- Orbach, A. (1999). *Life, Psychotherapy, and Death: The End of Our Exploring*. London: Jessica Kingsley.
- Ortiz, C. (2000). Learning to use humor in psychotherapy. *Clinical Supervisor*, 19(1), 191-198.
- Oxford English Dictionary (1933). Oxford: Clarendon Press.
- Papenfuss, M. (2015). Cannibal killer Jeffery Dahmer beaten to death over sick sense of humour, says prison murder. *International Business Times*. Retrieved from: <http://www.ibtimes.co.uk/cannibal-killer-jeffrey-dahmer-beaten-death-over-sick-sense-humour-says-prison-murderer-1499367>
- Paskoff, L. (1998). Abbott and Costello meet Aristotle and Freud: The fear of death evoked, neutralized by comedy and reborn. *Proceedings from the 1998 WHIM Conference*, 7:85-86.
- Pasquali, G. (1986). Some notes on humor in psychoanalysis. *The International Journal of Psychoanalysis*, 14(2): 231-236.
- Patton, M. Q. (2002). *Qualitative Research and Evaluation Methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Phillips, A. (1993). *On Kissing, Being Tickled and Being Bored*. London: Faber.

- Pierce, R. (1985). Use and abuse of laughter in psychotherapy. *Psychotherapy in Private Practice*, 3(4): 67-73.
- Pietroni, P. (1991). *The Greening of Medicine*. London: Victor Gollanaz.
- Poland, W. S. (1971). The place of humor in psychotherapy. *The American Journal of Psychiatry*, 128 (5): 653-657.
- Poland, W. S. (1990). The gift of laughter: On the development of a sense of humor in clinical analysis. *The Psychoanalytic Quarterly*, 59 (2): 197-225.
- Polanyi, M. (1958). *Personal Knowledge: Towards a Post-Critical Philosophy*. Chicago: University of Chicago Press.
- Polanyi, M. (1967). *The Tacit Dimension*. Chicago: University of Chicago Press.
- Polanyi, M. (1975). *Meaning*. Chicago: University of Chicago Press.
- Polkinghorne, D. E. (1988). *Narrative Knowing and the Human Sciences*. Albany NY: State University of New York Press.
- Polkinghorne, D. E. (1995). Narrative configuration in qualitative analysis. In J. A. Hatch & R. Wisniewski (Eds.), *Life History and Narrative*. London: The Falmer Press.
- Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology*, 52, 137-145.
- Poole, A. (2005). *Tragedy: A Very Short Introduction*. New York: Oxford University Press.
- Pratcett, T. (1991). *Witches Abroad*. London: Transworld Publishers.
- Raskin, V. (1985). *Semantic Mechanisms of Humor*. Holland: Reidel Publishing.
- Rawnsley, M. (1982). Brief psychotherapy for persons with recurrent cancer: A holistic practice model. *Advances in Nursing Science*, 10:69-74.
- Reck, A. J. (1977). A contextualist thanatology: A pragmatic approach to death and dying. *Death Education*, 1(3): 315-323.
- Reed, P. (1986). Death perspectives and temporal variables in terminally ill and healthy adults. *Death Studies*, 10 (6): 467-478.
- Reik, T. (1913). Psychoanalytische Bemerkungen über den zynischen Witz. In: E. Fabian (2002), On the differentiated use of humour and joke in psychotherapy. *Psychoanalytic Review*, 89: 399-412.
- Reik, T. (1936). *Surprise and the Psychoanalyst*. London: Kegan Paul.
- Reynolds, L. & Botha, D. (2006). Anticipatory grief: Its nature, impact, and reasons for contradictory findings, *Counselling, Psychotherapy, and Health*, 2(2): 15-26.
- Richman, J. (1996). Points of correspondence between humour and psychotherapy. *Psychotherapy*, 33(4): 560-566.
- Ricoeur, P. (1970). *Freud and Philosophy: An Essay on Interpretation* (trans. D. Savage). New Haven, CT: Yale UP.
- Ricoeur, P. (1984) *Time and Narrative. Volume 1*. (trans. K. McLaughlin-Blamey & D. Pellauer) Chicago: University of Chicago Press.
- Ricoeur, P. (1992). *Oneself as Another*. Chicago: University of Chicago Press.
- Riessman, C. K. (2002). Narrative Analysis. In: A. M. Huberman & M. B. Miles (Eds.), *The Qualitative Researchers Companion*. Thousand Oaks CA: Sage Publications (pp. 217-270).
- Riessman, C. K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage Publications.
- Rose, G. J. (1969) King Lear and the use of humor in treatment. *Journal of the American Psychoanalytic Association*, 17:927-940.
- Roche, M. W. (1998). *Tragedy and Comedy: A Systematic Study and a Critique of Hegel*. New York: State University of New York Press.

- Rolling Stones (2005). Laugh, I nearly died [song]. *A Bigger Bang*. London: Virgin Records.
- Roustang, F. (1987). How do you make a paranoid laugh? *Modern Language Notes*, 102:707-718.
- Ruch, W. (1998). *The Sense of Humor: Explorations of a Personality Characteristic*. New York: Mouton de Gruyter.
- Ruxton, J. P. (1988). Humor intervention deserves our attention. *Holistic Nursing Practice*, 2:54 – 62.
- Salameh, W. (1983). Humor in psychotherapy: Past outlooks, present status and future frontiers. In: P. McGhee and J. Goldstein (Eds.) *Handbook of Humor Research*. New York: Springer-Verlag.
- Saldaña, J. (2013). *The Coding Manual for Qualitative Researchers*. Thousand Oaks CA: Sage Publications.
- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health*, 18(2): 179-183.
- Saper, B. (1987). Humour in psychotherapy: Is it good or bad for the client? *Professional Psychology: Research and Practice*, 18(4): 360-367.
- Sartre, J-P. (2007[1938]). *Nausea*. (Trans. L. Alexander). New York: New Directions Books.
- Sartre J-P. (1943). *Being and Nothingness: An Essay on Phenomenological Ontology* (trans. H. Barnes). New York: Philosophical Library.
- Sartre, J-P. (1956). Existentialism is a Humanism. In: W. Kaufman (1988). *Existentialism from Dostoevsky to Sartre*. New York: Plume.
- Saunders C. (1978). Hospice care. *American Journal of Medicine*, 65(5):726-28
- Saussure, F. de (1966[1916]). *Course in General Linguistics*. New York: McGraw-Hill.
- Schelesinger, K. (1979). Jewish Humour as Jewish Identity. *International Review of Psychoanalysis*, 6:317-330.
- Schneider, K. J., Bugental, J. F. T. & Person, J. F. (Eds.) (2001). *The Handbook of Humanistic Psychology: Leading Edges in Theory, Research and Practice*. Thousand Oaks CA: Sage Publications (pp.275-288).
- Schopenhauer, A. (1964[1819]). *The World as Will and Idea* (trans. R. B. Haldane and J. Kemp). London: Routledge.
- Searles, H. (1965). *Collected Papers on Schizophrenia*. London: Hogarth Press.
- Shaftesbury, A. A. C. (1999[1711]). *Characteristics of Men, Manners, Opinions, Times*. Cambridge: Cambridge University Press.
- Shaughessy, M. F. & Wadsworth, T. M. (1992). Humor in counselling and psychotherapy: A 20-year retrospective. *Psychological Reports*, 70:755-762.
- Shaw, G. B. (2011[1906]). *The Doctor's Dilemma*. Auckland: The Floating Press.
- Shkedi, A. (2005). *Multiple Case Narrative: A Qualitative Approach to Studying Multiple Populations*. Amsterdam: John Benjamins Publishing.
- Shyrock, R. N. (1947). *The Development of Modern Medicine: An Interpretation of the Social and Scientific Factors Involved* (2nd Ed). New York: Knopf.
- Simon, J. M. (1990). Humor and its relationship to perceived health, life satisfaction, and morale in older adults. *Issues in Mental Health Nursing*, 11(1):17-31.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11: 261-271.

- Smith, J. A. (2007). Hermeneutics, human science and health: Linking theory and practice. *International Journal of Qualitative Studies on Health and Well-being*, 2(1), 3-11.
- Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.
- Smith, J. A. & Osborn, M. (2003). Interpretative Phenomenological Analysis, in J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage Publications (pp. 51-80).
- Social Care Institute for Excellence (2013). *Dying Well at Home: The Case for Integrated Working*. Retrieved from: <http://www.scie.org.uk/publications/guides/guide48/index.asp>.
- Spinelli, E. (1996). Some hurried notes expressing outline ideas that someone might someday utilise as signposts towards a sketch of an existential-phenomenological theory of sexuality. *Journal of Society for Existential Analysis*, 8: 2-20.
- Stephenson, R. G. (1993). Chapter 15 We laugh to keep from crying. *Loss Grief and Care*, 7:1-2, 173-179.
- Stewart, B. W. & Wild, C. P. (2014). *World Cancer Report 2014*. International Agency for Research on Cancer, World Health Organisation.
- Strean, H. S. (1994). *The Use of Humor in Psychotherapy*. Maryland: Jason Aronson.
- Sultanoff, S. M. (1994). Exploring the land of mirth and funny: A voyage through the interrelationship of wit, mirth, and laughter. *Laugh it Up, Publication of the American Association for Therapeutic Humor*, 3. Retrieved from: www.humormatters.com/articles/explore.htm.
- Sultanoff, S. M. (2000). Using Humor for Treatment and Diagnosis: A shrinking perspective. *Therapeutic Humor, Publication of the American Association for Therapeutic Humor*, 14 (1): 5.
- Sweeting, H. N. & Gilhooley, L. M. (1992). Doctor, am I dead? A review of social death in modern societies. *Omega - Journal of Death and Dying*, 24(4), 251-269.
- Taplin, O. & Billings, J. (2010). What is Tragedy? *University of Oxford Podcasts* [audio podcast]. Retrieved from: <http://podcasts.ox.ac.uk/series/what-tragedy>.
- Taylor, C. (1977). Death, American style. *Death Education*, 1(2):177-185.
- Taylor, S. J. & Bogdan, R. (1998). *Introduction to qualitative research methods: A guidebook and resources* (3rd ed.). New York: John Wiley & Sons.
- Telfer, E. (1995). Hutcheson's reflections upon laughter. *The Journal of Aesthetics and Art Criticism*, 53(4): 359-369.
- Thomas, P. D. (2009). Historical-critical dictionary of Marxism. *Historical Materialism*, 17:259-264.
- Thompson, L. M. (1984). Cultural and institutional restrictions on dying styles in a technological society. *Death Education*, 8(4): 223-229.
- Thorson, J. A. (1985). A funny thing happened on the way to the morgue: Some thoughts on humor and death, and a taxonomy of the humor associated with death, *Death Studies*, 9 (3-4): 201-216.
- Thorson, J. A. (1993). Did you ever see a hearse go by? Some thoughts on gallows humor. *Journal of American Culture*, 16(2), 17-24.
- Van Kaam, A. L., (1966). *Existential Foundations of Psychology*. Pittsburgh, PA: Duquesne University Press.
- Van Maanen, J. (1988). *Tales of the Field: On writing ethnography*. Chicago: University of Chicago Press.
- Van Manen, M. (1990). *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. New York: State University of New York Press.

- Van Wormer, K. & Boes, M. (1997). Humor in the emergency room: A social work perspective. *Health and Social Work*, 22(2): 87-92.
- Voce, A., (2004) *Introduction to research paradigms*. Handout for the Qualitative Research Module. Retrieved from: <http://www.scribd.com/doc/78832156/Introduction-to-Research-Paradigm>.
- Walsh, R. (2003). Fictionality and mimesis: Between narrativity and fictional worlds. *Narrative*, 11(1), 110-121.
- Warner, S. L. (1991). Humor: A coping response for student nurses. *Archives of Psychiatric Nursing*, 5(1):10-16.
- Watson, M. & Kissane, D. W. (Eds.) (2011). *Handbook of Psychotherapy in Cancer Care*. Chichester: John-Wiley.
- Weir, R. (1980). A realistic perspective on death. *Education*, 4:1, 77-87.
- Weisman, A. (1972). *On Dying and Denying: A Psychiatric Study of Terminality*. New York: Behavioral Productions.
- Welsford, E. (1935). *The Fool: His Social and Literary History*. London: Faber & Faber.
- Wertz, F. J., (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology*, 52 (2): 167-177.
- World Health Organisation (2014). *WHO Definition of Palliative Care*. Retrieved from: <http://www.who.int/cancer/palliative/definition/en/> on 23rd December 2012.
- Winnicott, D. (1971). *Playing and Reality*. London: Routledge.
- Wong, P. T. P. & Tomer, A. (2011). Beyond Terror and Denial: The positive psychology of death acceptance. *Death Studies*, 35(2): 99-106.
- Yalom, I. (1980). *Existential Psychotherapy*. New York: Basic Books.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15:215-228.
- Zupančič, A. (2003). *Ethics and Tragedy in Lacan. A Cambridge Companion to Lacan* (Rabaté, J, Ed.). Cambridge University Press (pp. 173-190).

